THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

NOVEMBER, 1951

Fairview Hospital, LaPorte, Ind.

Saves $332 per Month



At Fairview Hospital, linens and uniforms are quickly washed sterile-clean in 36 x 54" CASCADE Washer, and 22x25" CASCADE End-Loaded Washer (being unloaded). At right, 30" Extractor gently removes excess water from washed work to prepare it for fast ironing or drying.



Flatwork is beautifully and quickly ironed on 2-Roll STREAM-LINE Flatwork Ironer, left. With SUPER-ZARMO and SUPER-ZARMOETTE Press Unit *(right)*, one operator completely machine-irons uniforms at exceptionally low cost.

In order to have a more self-sufficient operation, 76-bed Fairview Hospital installed an "AMERICAN" planned and equipped laundry. After the first two months' operation, a careful check of their cost figures showed that the new laundry *had saved the hospital $332 per month.* Faster return of linens to service . . . smaller linen inventory required . . . better quality work . . . were additional benefits reported.

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Consult our Laundry Advisor . . . He will make a thorough analysis to determine whether you are handling your soiled linen problem most efficiently and economically. If justified, he will recommend proper laundry equipment to meet your hospital's particular needs. He will submit a detailed floor plan for the laundry layout . . . suggest the most economical, efficient method of operation. The free services of our Laundry Advisor are available to Hospitals, large or small, without any obligation whatever. WRITE TODAY.

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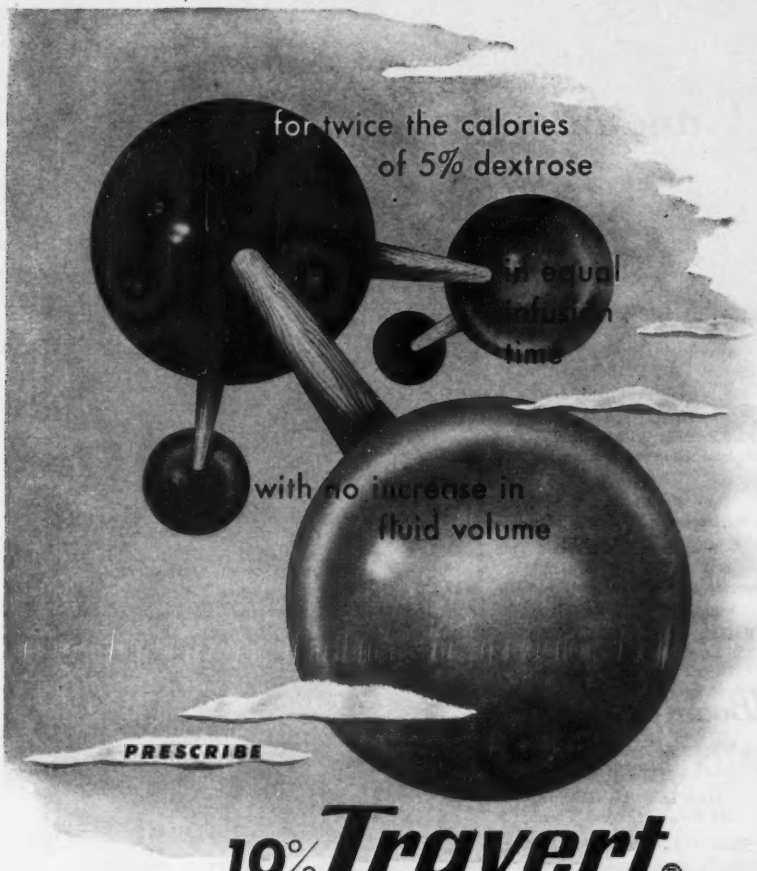
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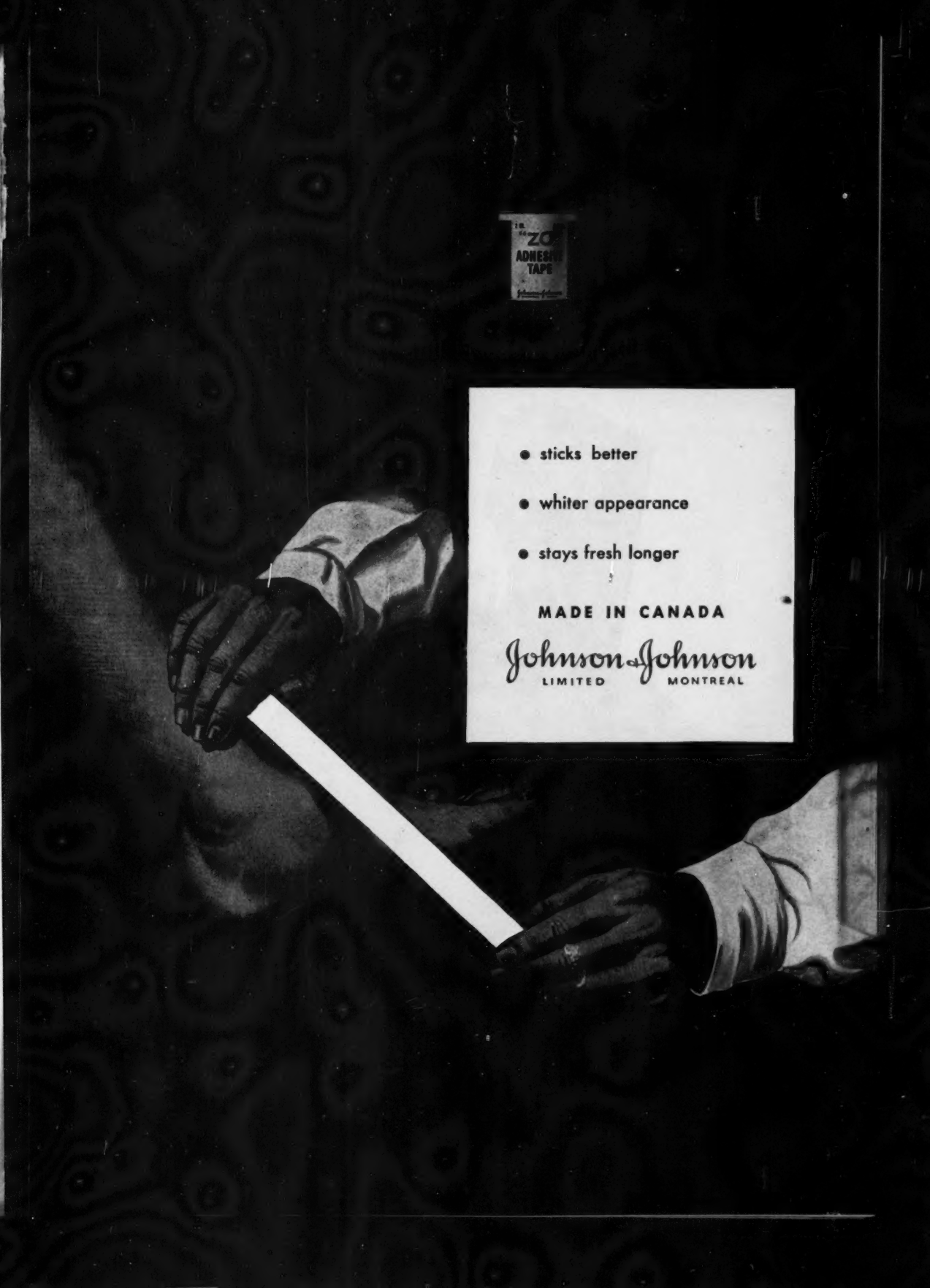
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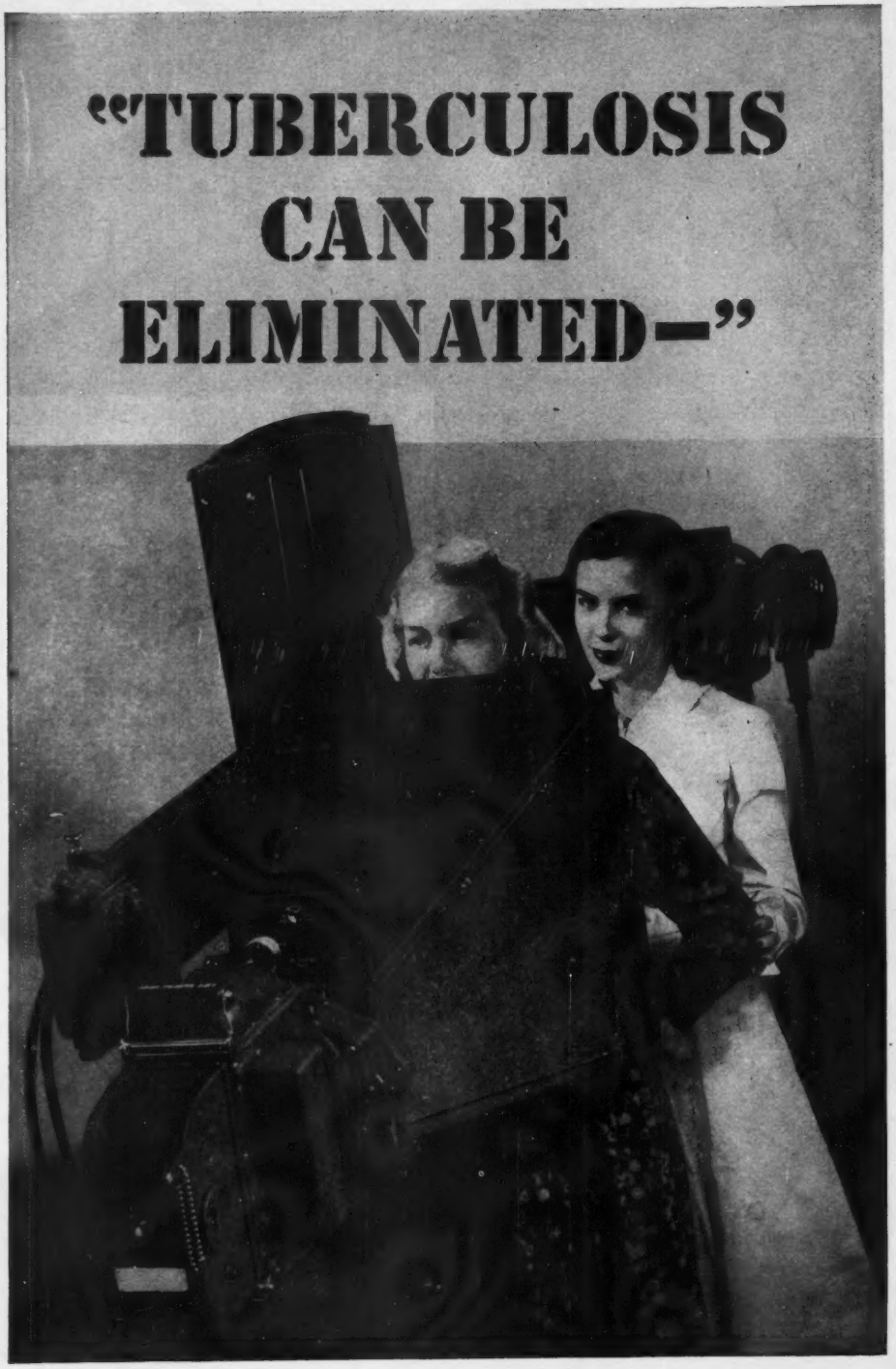
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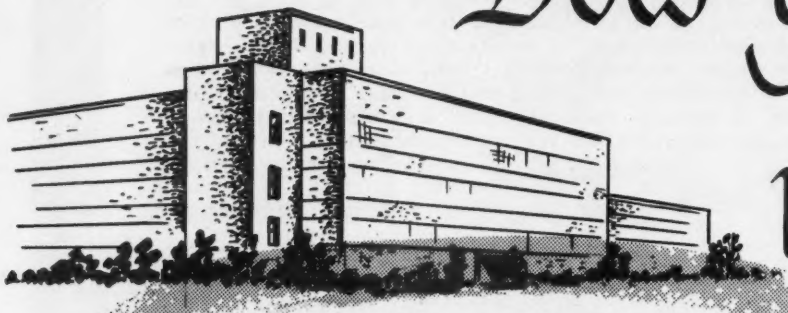
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Does your need



If yours is one of the many voluntary hospitals without enough beds to serve its community fully and adequately, and without sufficient funds to provide them, then the following message is of vital concern to you, your hospital and your community.

If you are the head of a voluntary, non-profit hospital in need of additional facilities, you are in an excellent position to obtain building funds if you can answer "YES" to each of the following statements:

1. *Your community has a* **demonstrable** *need for more hospital beds.*
2. *Business, industry, commerce and individuals in your community have enough* **disposable** *income to permit them to contribute to your hospital.*
3. *A representative proportion of the* **leading** *citizens in your community have, or could be induced to take, an active interest in your hospital.*

If your answer to any of these statements is "NO", then your chances of obtaining the *large* sums of money required to meet present day hospital construction costs are poor.

What if the answer to all three is "YES"? You can follow one of two courses:

You can make your own appeal to the community, pointing out that it needs more hospital facilities for its own protection, that the money is available, that you need so many hundred thousand or so many million dollars and will the community please contribute the money?

Such a self-directed appeal will bring in many contributions. It may, if unusually successful, bring in a great many contributions. But invariably you will find that the total of all the contributions is an insignificant fraction of the amount you need even for the most modest hospital expansion.

Obtaining the many LARGE contributions that will add up to the total you will need, involves highly complex and highly skilled techniques. These techniques cannot be learned over night. Their successful application takes many years to perfect. No matter how willing, how hard working and how conscientious the workers in a self-directed appeal may be, the simple fact is that they do not have the techniques necessary to raise LARGE sums of money.

If this were not true, there would be no need for professional fund-raising organizations such as Lawson Associates.

hospital more beds?



Your second course is to consult a reputable, experienced, professional hospital fund-raising counsel. This consulation will cost you nothing. If you were to consult Lawson Associates, here's what would be done:

Following the consultation, the Lawson research staff would survey the economic, social and psychological factors in your community which affect the outcome of a hospital fund-raising campaign. (This survey also is generally provided by Lawson Associates at its own expense.)

If analysis of the survey data indicated that a campaign could be successful, you would be so advised and would be told the reasonable amount the campaign could be expected to produce.

(If a campaign were not deemed feasible, you would be given the reasons. We cannot afford to become involved in a campaign that is apt to fail because it would injure our reputation and harm our business.)

When a campaign is feasible, a detailed Plan of Campaign, tailored to the specific needs of your hospital and your community, would be prepared. This written plan states exactly what will be done, how it will be done and when it will be done.

With this plan you would receive a contract form giving the fee for our services. This is always a fixed fee, never a percentage of the goal or of the amount raised. You also would receive an estimate of what it would cost, in addition to our fee, for clerical help, postage, promotional literature and other campaign expenses.

A well-trained, experienced Campaign Director, with the necessary number of Associate Directors, would move into your community to devote themselves to the success of your campaign. It is to the interest of these directors to make your campaign a success because their future and that of the firm for which they work depend upon it.

These men direct, inspire and train the volunteer workers. They guide you in selecting and enlisting the top campaign personnel. They keep the activities outlined in the Plan of Campaign moving smoothly and on time. They prepare all the written material used in the campaign and handle all the publicity and public relations.

These are but a few of the major reasons why—if your hospital needs funds for expansion—you will be wise to consult Lawson Associates. You have everything to gain, nothing to lose, through this free consultation.



For a more detailed account of how professional hospital fund-raising can help you and your hospital, we have prepared a FACT FILE on the subject which will be sent to the head of any hospital requesting it on hospital stationery. Write Dept. CH-11

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Across the Desk

By C.A.E.

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(Continued on page 16)



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Across the Desk

(Continued from page 16)

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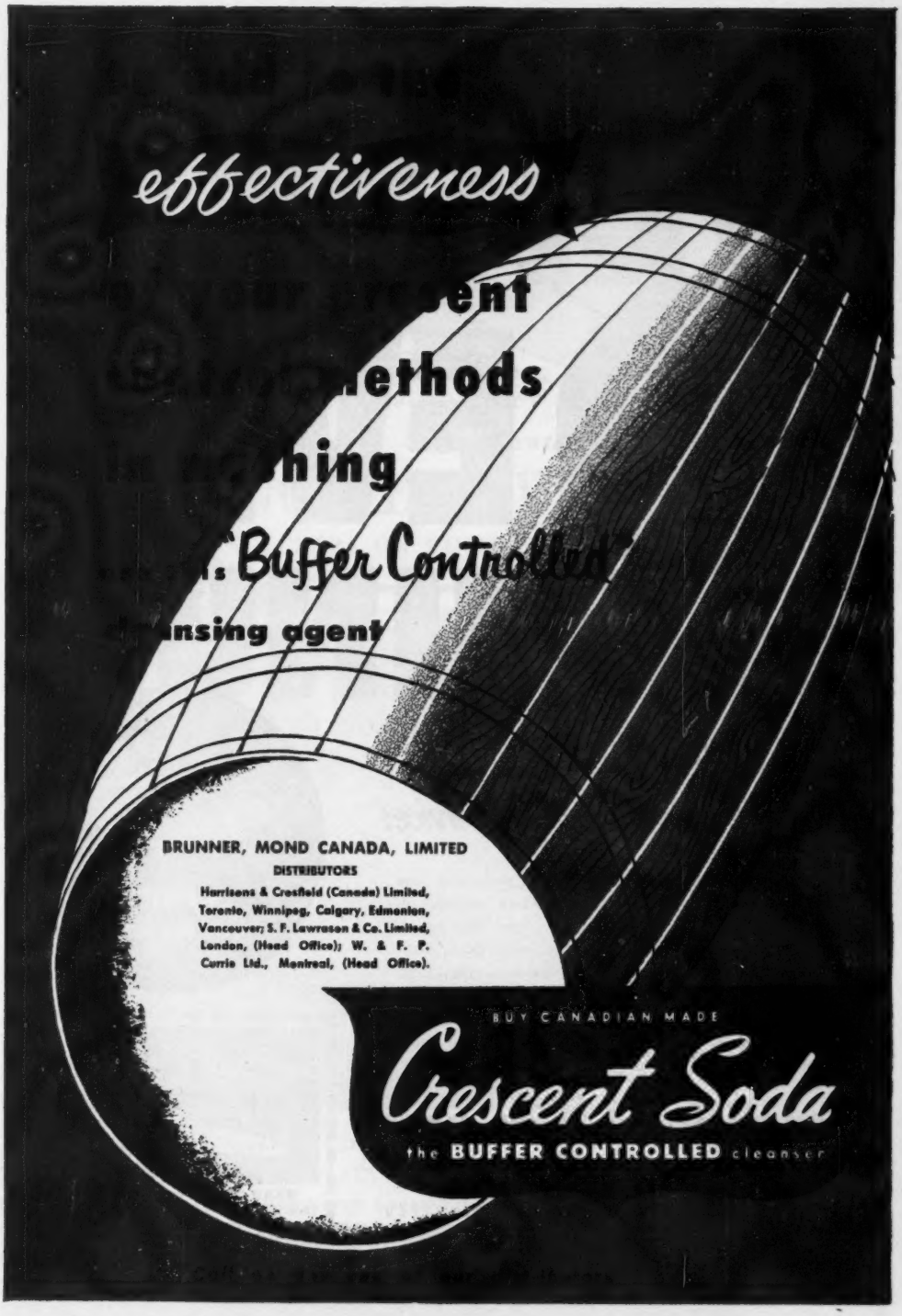
* * * *

Plant Expansion, Terramycin Price Cut, Announced by Pfizer Company

A major cut in the price of terramycin has been announced by John E. McKeen, president of Chas. Pfizer & Co., Inc.

The price cut, which ranges from 15 per cent on oral capsules to 40 per cent on that used for injections, results from a $15,000,000 long-range expan-

(Concluded on page 22)


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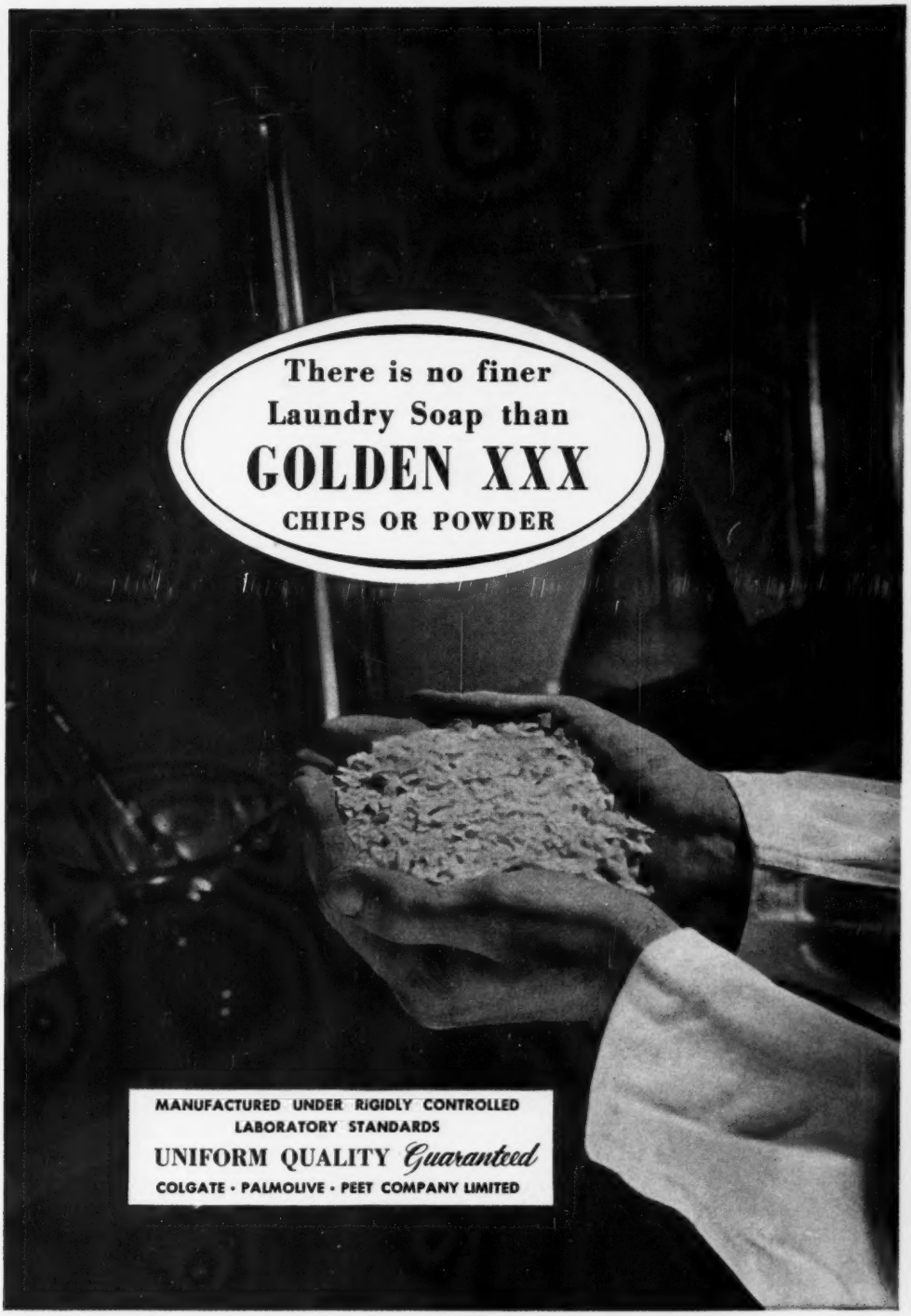
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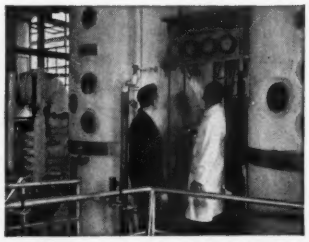
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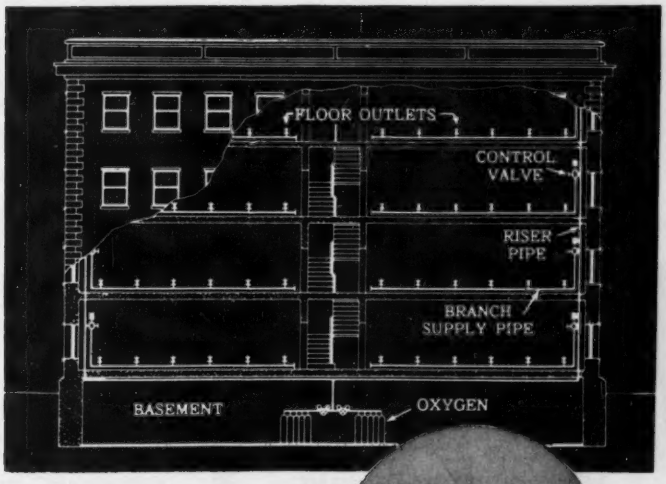
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Across the Desk

(Concluded from page 16)

sion program, which to date has more than doubled Pfizer's antibiotic fermentation capacity.

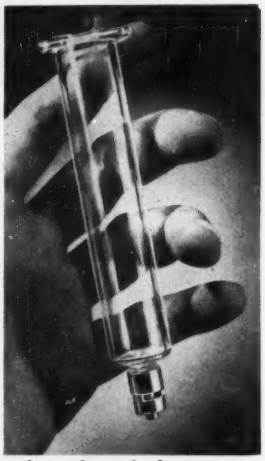
"The findings of clinical investigators throughout the world have created a tremendous demand for increased supplies of terramycin to curb diseases such as brucellosis, amœbic dysentery, yaws, trachoma, typhus, penumonia, venereal diseases—altogether a total of more than fifty major human infections. The demand for terramycin can now be more nearly met," Mr. McKeen said in announcing the increased production and reduced price of the earth-mold drug.

The new price schedule became effective as of September 27, 1951.

* * * *

B-D Introduces Dynafit Syringe With Unground Barrel

Described as "the most important development in syringe manufacture since the all-glass hypodermic syringe was introduced by B-D in 1898", Becton, Dickinson and Company, of Rutherford, N.J., has announced the B-D Dynafit Syringe.



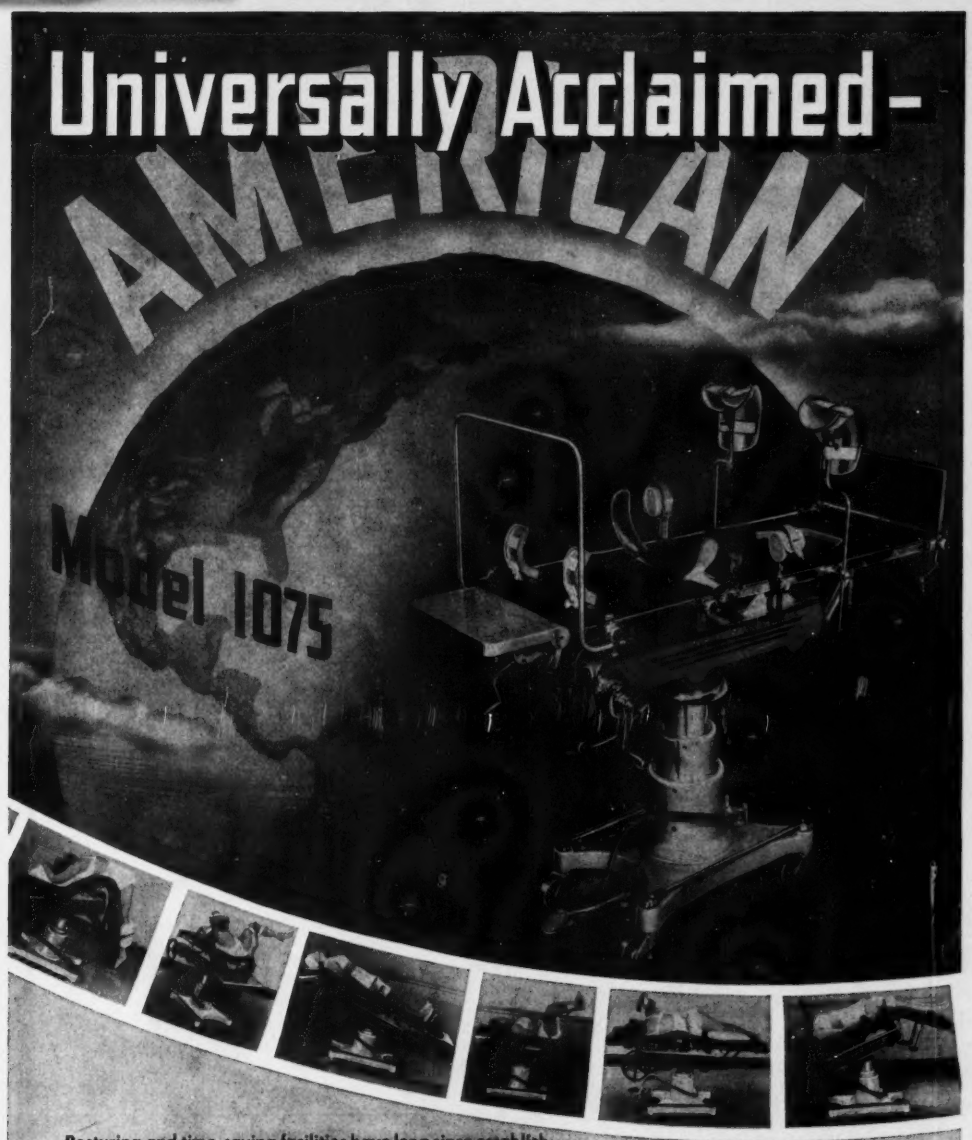
The new syringe differs from ground-glass hypodermic syringes now in use in that it has an unground barrel. Until now, it is pointed out, the plunger and barrel of a hypodermic syringe have been fitted by grinding the external surface of the plunger and the inside surface of the barrel. Although the ground-glass surfaces look smooth to the naked eye, actually they are rough and pitted, as may be seen under a microscope. As the syringe is used, the two ground-glass surfaces rub against each other and the friction gradually wears each surface down util the syringe "back-flows" and must be discarded as worn out.

Furthermore, grinding the inner surface of a syringe barrel removes the "skin" of the glass and exposes the "pores" to erosion during sterilization procedures. Removal of the "skin" by grinding also lessens the inherent resistance of the glass to breakage.

At present the B-D Dynafit Syringe is available in 2 cc., 5 cc., and 10 cc. sizes in individual packages and in Hospital Packages of 3 dozen of a size.

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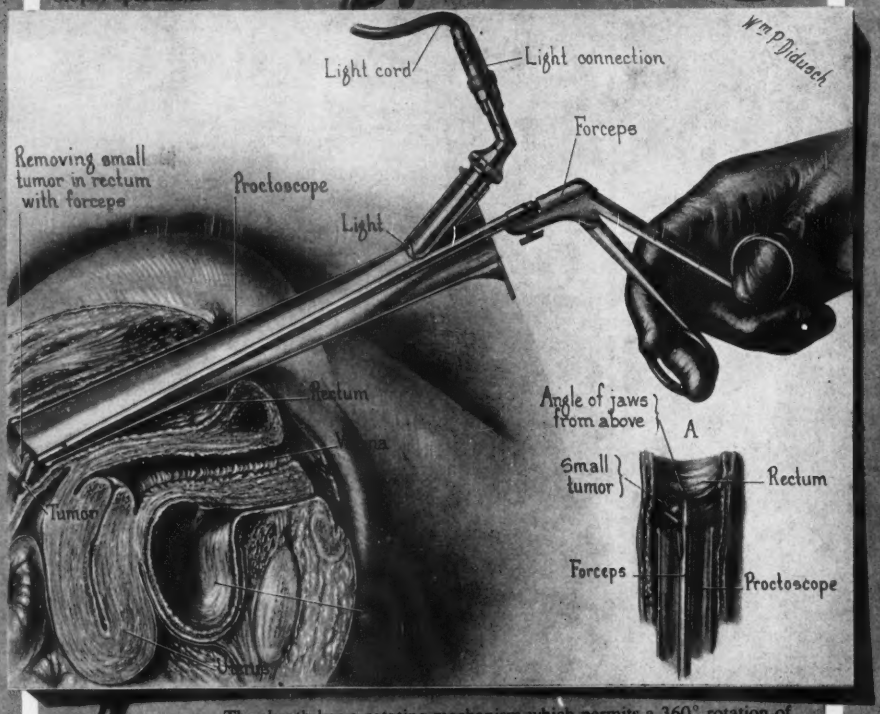
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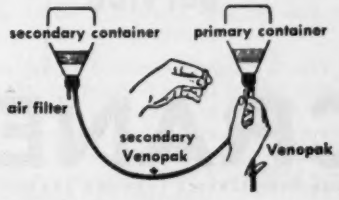
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L. O. Bradley, M.D., Editor

CANADIAN HOSPITAL

Toronto, November, 1951 Vol. 28 No. 11

Obiter Dicta

The Teaching Hospital — an Asset to the Community

THERE are at least two long-term aspects to a recent unfortunate and unwarranted outburst against Sunnybrook Hospital (D.V.A.) that are of more significance than the temporary unpleasantness. They overshadow any harm that might have been done by this ill-advised attack.

It was encouraging and re-assuring to see the press, the public, and the most important group the *patients and ex-patients*, rally to support the institution. This spontaneous counter-attack emphasizes again the most vital element in the whole scheme of community relations. It is that *nothing can replace good service as the corner stone of a public relations program.* While those whom a hospital serves may not understand very much about operating a hospital, they do know when they've been well treated.

One statement made was that patients became guinea pigs in the teaching of medical students. It is not important that the clinical facilities of Sunnybrook *are not used* to give instruction to medical students. What is important is that there should be any reservation about using a hospital for the preparation of medical students.

Every hospital is a teaching hospital and a hospital is *better* for being a teaching institution. A program of medical education in a hospital adds another discipline to the many in medical practice. A teaching program means that each case must be carefully prepared and investigated before it reaches the classroom or clinic. There it is reviewed and every angle explored. Laboratory and x-ray tests are complete. Follow-up is even more thorough for many become interested in the progress of the case. The outcome is that the existing disciplines of medical practice are further strengthened by the presence of inquiring and alert young minds.

But many in our communities do not understand that one of the basic functions of their hospital is education and that a good teaching or training program means a higher quality of care for them. It is vital that they know and understand these truths. Patients who realize these values are ready and willing to participate in the program. It becomes a contribution to the welfare of the community which cannot be measured in dollars and cents for it may mean lives later. It is a means of removing the "private, semi-private" barrier that sometimes limits a teaching program and denies these patients many advantages.

A good public relations program should carry this thought, for every hospital is now interested in its community relations. The medical staff are naturally interested and will want to participate in the program. We must leave no doubt in the minds of the community that a teaching program will mean better and safer care.

C. I. P. S. — A Service to Hospitals

AFTER an uncertain start several years ago, the Canadian Intern Placement Service (C.I.P.S.) of Camsi (Canadian Association of Medical Students and Interns) is now soundly established. The success of last year's operations is evidence that it is accepted as a most useful instrument for intern placement.

This Canadian approach to intern placement received an unusual compliment from south of the border. After a very successful trial run by the Association of American Medical Colleges last year, the National Inter-Association Committee on Internships is this year sponsoring a plan in the U.S.A. that is very similar to its Canadian predecessor.

One factor in the success of C.I.P.S. last year was the conformity of the Canadian placement dates with those of the U.S. trial plan. To hold this advantage, it has been necessary to amend the assignment date to March 14th, 1952. (See page 72 of this issue.) This change will also answer the criticism of some of our intern committees who felt that the February date was too early.

In order that this placement service may be of maximum value to interns and hospitals alike, C.I.P.S. urges administrators to record the names of *all* student applicants *in order of preference,* as requested. In their experience, failure to do so is chiefly responsible for the inability of certain hospitals to fill their intern quotas. For instance, a hospital with 15 vacancies may receive 40 applications but if the administrator furnishes C.I.P.S. with only 20 names, the service is quite unable to interpret the desires of the administrator concerning those applicants who are not mentioned.

C.I.P.S. does not undertake to influence the application of students, it simply acts as an agency to correlate the desires of both students and hospital administrators by assigning students to the best available internship in accordance with the desires of both.

The task that C.I.P.S. has assumed is not an easy one for no system of distribution can satisfy exactly the demands of all hospitals. It is creditable that so few complaints or criticism have come forward. While some 1,718 openings are approved by a C.M.A. committee in 73 hospitals, there are about 700 potential candidates before the loss to U.S. hospitals. Far fields look greener but perhaps we need to mend some fences and to cultivate some greenery at home.

To the potential intern, the primary attraction, above all other inducements, is a first-rate teaching program. Comfortable living quarters with a small honorarium certainly add to the package but they are minor ingredients beside an active and well organized educational opportunity. Hospitals experiencing some difficulty in filling their needs might well review and evaluate their programs.

Hospital management is responsible for good living quarters, good meals, and favourable living conditions in general. A genuine interest by the hospital administration in the welfare of the intern will create a positive attitude in the whole staff and this will help recruitment. The main responsibility for attracting interns, however, rests inescapably with the medical staff. No amount of activity or interest by the administrator can fill the breach if the medical staff does not carry the ball.

The reputation for a top-notch training program cannot be quickly or painlessly won. A sound medical staff organization presents some difficulty at times though not nearly as much as the completion of adequate medical records which are vital to teaching and research. Building and maintaining a well-rounded educational program demands unselfish and sustained efforts. All too often it looks good on paper but turns out to be a hollow shell on closer examination. Regular clinico-pathological conferences, ward rounds, medical staff meetings, a high percentage of autopsies, an established medical audit, and so on, must be regular fare. A medical staff must mean business in order to organize and carry such a program.

Even then, it may take some time to attract applications, for good news travels much more slowly than bad news. No method of spreading the story is as effective as a satisfied graduate of a good program. So medical staffs and hospitals, having worked hard to meet the above conditions, need not feel discouraged if their toil does not bear fruit for several years. In the meantime, the leaven of education will transform the hospital beyond recognition and the medical staff will take on a new life. A good program will do as much for staff members themselves as a group and for their patients as it can do for the much sought-after intern.

Progress Report on CHAM

THE initial draft of the Canadian Hospital Accounting Manual (see October issue p. 40) is being compiled at the present time and copies of the first few chapters have been circulated for comments and suggestions.

At a recent meeting of eastern members of the Committee on Accounting and Statistics, the suggested content of the manual was discussed in some detail, together with related problems. CHAM will be reviewed by the Dominion Council of Health within the next few weeks.

At this time we wish to acknowledge the help of Father Bertrand, in connection with the French edition, and to announce that Lucien Hébert, superintendent, Hôtel-Dieu de Sherbrooke, Sherbrooke, P.Q., and Paul-Emile Olivier, administrator, Bégin Sanatorium, Lac Etchemin, P.Q., have graciously consented to supervise the translation of the French edition.—*R.M.C.*

Elementary Law } For Hospital Trustees and Administrators

Part I

Nelles V. Buchanan, K.C.,
Solicitor,
Associated Hospitals of Alberta,
Edmonton, Alta.

THIS article is confined to "elementary law" and to that portion which is deemed to be of particular interest to members of hospital boards and those engaged in the administration of hospitals. This is the day of specialization, for medical practitioners as well as for lawyers. If lawyers are forced to specialize, then much more so are hospital administrators and trustees, insofar as the law is concerned. Thus, my object will not be so much to inform as to set up warning signals and to convince you —if you are not already agreed— that the path of hospital boards and administrators may be cleared of many obstacles by the use of what might be termed "preventive law".

For our purposes, "the law" may be defined as the general body of rules recognized and enforced by the state in the administration of justice and the maintenance of good order. The term "law" may be used in two senses, abstract and concrete. In the abstract sense, we speak of "the law of England", "the law of libel", "criminal law". In the concrete sense we say that Parliament has enacted a law, and we speak of the by-laws of a hospital. The concrete term is much narrower in its application than the abstract.

In the mouths of lawyers, the words "the law" are habitually used in the abstract sense. When they have the concrete idea in mind, they speak of some particular species of law, statutes, acts of parliament, and rules of court.

Four brief definitions may be useful. By *criminal law* we mean the law relating to offences considered injurious to the community as a whole. The object of criminal law is the punishment of the offender and the punishment can be remitted only by the Crown.

Civil law is now used as the name for that part of the law of a state not considered to fall within the criminal law. The object of civil law, broadly stated, is to adjust the rights of individuals.

Sometimes called the unwritten law, *common law* consists of the rules of law developed and evolved by the judges in the courts.

Statute law, or written law, consists of express enactments by legislature or by parliament.

The following three departments have been arbitrarily selected for discussion here:

1. Hospital liability for the actions of its medical staff, nurses or administrative staff, to patients, visitors, to the hospital, and employees;

2. Statute law which is peculiarly applicable to hospitals, including methods of securing reforms and amendments to these laws;

3. Certain administrative problems.

Hospital Liability

Undoubtedly a question of grave concern to the administrative officers, the medical and nursing staffs, is: Under what circumstances can the hospital be ordered to pay damages for the negligent acts of any hospital employee or of the hospital in its corporate activities?

The answer to this question is: When a tort (French "wrong") has been committed. This calls for a brief explanation of that variety of injury or wrong known as a tort within which classification negligence falls. A tort is simply an act done by A to B whereby A without just cause or excuse has caused some form of harm to B. B then has an action for tort, a claim for money compensation.

The variety of torts are numerous: conversion of property, assault, defamation (libel when in permanent form, slander when spoken or gestured), malicious prosecution and negligence, and many others. They all fall within the definition and the remedy always is civil action for money damages. Of these torts, we shall discuss only the following which are of especial interest to hospitals: negligence, assault, conversion of property, and defamation (libel or slander).

Negligence

What is the tort known as negligence? It is conduct which involves an unreasonably great risk of causing damage. It is omitting to do something which a reasonable man would do or doing something which a prudent and reasonable man would not do. Negligence indicates the breach of a duty and damage thereby suffered by the person to whom the duty was owing. There is no liability for negligence unless there is in the particular case a legal duty to take care and this duty must be one which is owed to the plaintiff himself and not merely to others. The law does not require the highest degree of care. The question always is whether the defendant attained to the standard of due care established by law. The care taken by a common and prudent man has always been the rule laid down, *i.e.*, "the man who takes the

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An address presented at the Sixth Institute for Hospital Administrators and Trustees of Western Canada, Edmonton, June, 1951.

magazines at home and in the evening pushes the lawn mower in his shirt sleeves". The burden of proving negligence is on the plaintiff who alleges it.

Contributory negligence: Harm is sometimes suffered by a plaintiff not solely through the negligence of the defendant but also through that of the plaintiff himself. Under our Contributory Negligence Act, a judge is permitted at trial to assess the degree of negligence or the percentage of negligence of which the plaintiff and the defendant are guilty.

The following cases extracted at random from the hundreds of similar cases available illustrate the various forms of negligence which the courts have held to be actionable and satisfaction for which has been given in the form of money compensation, otherwise known as damages. The following six cases deal with the liability of the hospital to patients.

Case I

The plaintiff is brought to the hospital by his family physician to be operated upon for a ruptured appendix. Operation is successfully performed with duly qualified nurses in attendance. To combat shock following operation, two rubber hot water bottles placed inside flannelette bag were filled by the matron with quite hot water and placed in the plaintiff's bed. The next morning it was discovered that the plaintiff's left leg had been severely burned. The Supreme Court of Canada held that the proximate cause of the accident was, in the first place, the filling of the bottle with water that was much too hot without any test of it; then the failure to test and see whether any adjustment was necessary. The failure to investigate was attributable to the nurse. Held that the obligation undertaken by the hospital was not merely to supply properly qualified nurses but to nurse the plaintiff. It was the negligence of the hospital in discharging the contractual obligation that caused the severe injury of which the plaintiff complained. Judgment for the plaintiff. *(Karl Nyberg vs Provost Municipal Hospital Board, 1927 S.C.R. 226)*

Case II

The plaintiff sues upon the ground that shortly after an operation, while under the influence of a sedative, but not yet asleep, she was permitted to roll out of bed and, secondly, that after a very serious and delicate operation and before the process of healing was complete, one of the nurses had attempted to replace a tube. The sutures were torn and thus all beneficial results of the operation were destroyed. A supervisory nurse without the advice or assistance of the patient's own physician and upon the suggestion of an intern, an employee of the hospital, re-inserted a tube which had partially come through the wound. Held by an Alberta Supreme Court Judge that the fall out of bed was the result of lack of reasonable care on the part of the nursing staff and that in respect to the attempt to replace the tube and tearing of the sutures there was lack of proper management and control in the operation of the hospital, that there should have been immediate communication with the patient's doctor as soon as it was discovered that the tube was slipping out and that no nurse should have been permitted to tinker with the tube. Damages of $15,000 were awarded to the patient. *(Beatty vs Sisters of Misericorde of Alberta, 1945, (1) W.W.R. 651)*

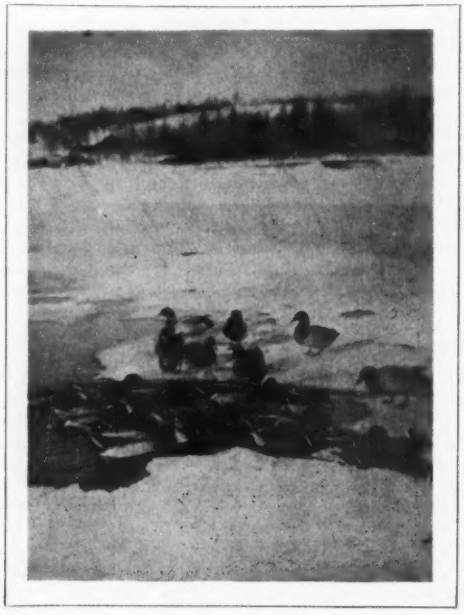


Photo by Eileen Scott

Case III

The plaintiff was admitted to defendant hospital. Her condition was diagnosed by her physician as sciatica. The supervising nurse was ordered to see that patient was given diathermic treatment to relieve her pain. Treatment given by a nurse, a permanent member of the staff. Patient's physician had nothing to do with actual treatment. Patient was burned. Court held the nurse was negligent, that she was the agent and servant of the hospital. Damages of $3,000 awarded by the Supreme Court of Canada. *(Fleming vs Sisters of St. Joseph, 1938. S.C.R. 172)*

Case IV

A child was brought to hospital suffering from pneumonia and steam inhalation ordered. Appa-

(Continued on page 76)

A Suggested Step Forward

Central Schools for Nursing Education

Gertrude M. Hall,

General Secretary-Treasurer, Canadian Nurses' Association, Montreal, P.Q.

ARE we moving any closer to a solution of one of Canada's foremost and most complex problems—nursing now and for the future? This question was repeated in varying forms time and again as we journeyed across this vast Dominion during recent months.

Pointing to the experiments in nursing education already under way in Canada, stressing the need to await the results thereof before making hasty conclusions, did not always satisfy those who posed such queries. Turning then to other patterns which have been tried to a limited extent elsewhere, we sought to interpret and encourage the idea of central schools of nursing. Sporadic waves of interest in this pattern have arisen from time to time—just enough to encourage a few nursing leaders here and there to put down their ideas, plans, and suggestions. The ideas are there all right but the need for financial assistance has, we believe, proved too much for those promoting plans for central schools of nursing. Only recently has there been any marked interest, on the part of those who control the purse strings, in any proposals concerning nursing education where financial assistance is required.

Thus it has seemed that all the dreams and all the plans for any change or marked deviation from the present pattern were doomed before the ink had dried upon the paper. Some observers believe that what is needed now is a definite appeal on the part of one or more provinces for permission to use part of the federal grant allocated to research, this money to be used to set up an experiment for a central school of nursing.

What is a central school of nursing? A "central school" has been defined as one whose administrative and educational personnel is organized so as to constitute an educational entity, although the students' clinical experience is secured in more than one hospital and sometimes in other agencies as well. A central school may or may not be a collegiate school; it may or may not grant a degree; it may be initiated in situations where a school of nursing has not previously existed; or, by mutual consent, two or more schools may merge their resources, facilities, and personnel, and each school lose its identity in the larger whole. Once established, such an institution will drop the word "central" from its name, the process being one of centralization and the result simply a school of nursing which offers the entire basic curriculum.

Why Centralize?

If we accept the premise that the nurse of today must be prepared for the continuous evolution of modern health work—hospital and community—then we must also endeavour to provide a basic program which will include: integrated teaching of all the sciences, biological and social; more types of clinical experience; better integration of the preclinical and clinical portions of the curriculum; permeation of the entire curriculum with the preventive as well as the curative, and the mental as well as the physical aspects of nursing; more emphasis upon the care of the ill in the home and in emergency situations; greater attention to the student's physical, emotional, intellectual and social development; larger consideration of the function of the nurse as a citizen and as a member of the health services.

Is it reasonable to expect that all the present hospitals conducting schools of nursing in Canada, ranging as they do from 50 to 1,500 beds, should or could each develop a basic program of the type necessary to prepare nurses to meet the needs of modern society? It may be logically argued that many if not all the present schools have much to contribute. It is exactly for this reason that we believe so fervently in the idea of pooling all possible resources and utilizing them to the fullest extent. Many, if not all, of the present schools are operating, however, with a limited number of properly qualified teaching and supervisory personnel. There are never enough teachers of nursing. Some schools still lack laboratories, libraries, and other essential teaching facilities.

Pooling resources and personnel may be the answer to some of these problems. This will, naturally, call for co-operative planning. One of the schools which has not admitted increased classes may have lecture rooms and laboratories that will accommodate some of the students in the enlarged classes of another school. If a college or a university is participating in the co-operative planning, its classrooms and laboratories may also be utilized. Public buildings of various types may likewise provide classroom accommodation for a group of schools. When schools get together for joint planning, even the least progressive school sometimes has something to contribute.

The fact that schools for which a co-operative plan is being made have different curricula and different admission standards introduces problems which may at first seem insurmountable. Group thinking, however, can usually find solutions to the various problems that arise. Co-operative

(Continued on page 90)

Courtesy "The Canadian Nurse" in which publication this article also appeared.

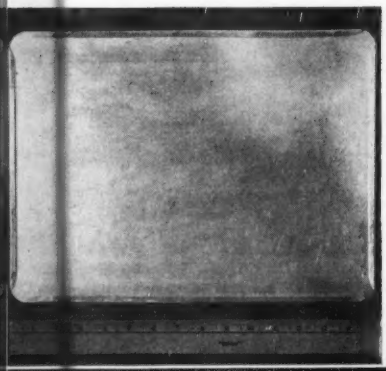
Double Purpose Served by

Modified Laparotomy Sheet

Dominque Gaudry, M.D.,
Chief of Surgical Service,
Hotel Dieu St-Vallier,
Chicoutimi, P.Q.

THE ordinary laparotomy sheet has assumed new duties in our operating room by the simple addition of two metal plates. We have found that by inserting these plates into the sheet at the proper places, a most convenient surgeon's table can be obtained. We have made use of this discovery for a great variety of operations and it has been of real value. As we have not seen this idea in use elsewhere, we believe that is original with us, although we have not undertaken any investigation in the matter.

Figure 1



This is how we have found the idea to be practical. We used an ordinary laparotomy sheet—the kind in use at our hospital is 8 feet long, and 5 feet, 3 inches wide. In the centre of its width, we cut an opening, 6 inches wide and 10 inches long, 2½ feet from the top of the sheet. Then we made two sleeves, 15½ inches wide and 11½ inches long, by sewing 2 pieces of cotton to the lower part of the sheet, close to the center opening.

The metal plates (15 inches wide, 11 inches long) are made of aluminum, $\frac{3}{32}$ inch thick. The corners are rounded and the ¼ inch border is folded under to add rigidity and smoothness (fig. 1).

To form the table, the metal plates were slipped into the sleeves and secured by tape. The sheet was then folded over the central opening and marked to indicate which part was to be placed towards the head.

In actual usage, the sheet is unfolded, first, on each side of the table, then, toward the head, and finally the bottom part of the sheet containing the two plates is placed toward the feet. The sheet can be placed on the patient with perfect aseptic technique. When the part of the sheet near the lower border of the central opening is held taut and slightly downward, the bottom part of the sheet, including the plates, can be easily unfolded. The plates fall well in place and the rest of the sheet is not displaced (figs. 2 and 3).

Advantages

This special laparotomy sheet offers many advantages. First of all, it provides a surgeon's table which is conveniently placed just a few inches away from the op-

1. The metal plate.
La plaque de métal.
2 & 3. How the laparotomy sheet is unfolded with aseptic technique.
Le champ de laparotomie est déplié avec une technique aseptique.

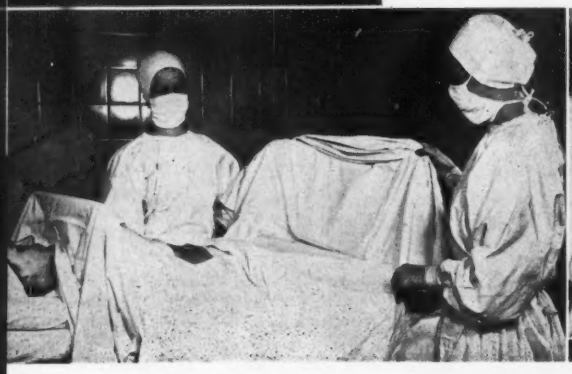


Figure 2

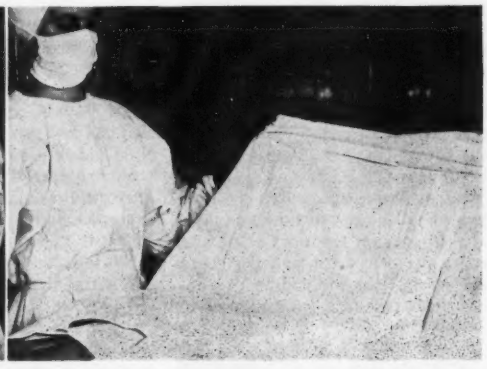


Figure 3

erative field. The normal friction of the sheet will keep this table securely in place as demonstrated in figures 4 and 5. The metal plates, sterilized with the sheet, assure a perfect asepsis even without any other covering than a single sheet of cotton. This part of the sheet can be soaked with saline, blood, and exudate, without any danger of contamination by capillarity from underneath.

This surgeon's table, about 24 inches long and 15 wide, is larger than the usual table stand and is level with the operative field. The lower plate is usually slightly slanted down towards the foot. This slight inclination is not sufficient to make the instruments and accessories slide down. A number of bulky instruments and accessories such as retractors, suction tubes, and kidney basins can be placed on the table as demonstrated in figure 5. Operating room technique is thus simplified and equipment kept to a minimum as the table stand is eliminated and the special laparotomy sheet takes its place.

This sheet is also easy to launder, sterilize, and fold, as it takes only a few seconds to slip in and out the metal plates. When folded, it looks like any ordinary laparotomy sheet (fig. 6).

Under certain circumstances, for instance if the sheet is to be placed toward the foot of the operating table or over a young child, the lower or both plates may have to be removed. This can easily be done before the sheet is placed or else at the time it is unfolded, as is shown in figure 7.

* * * * * *

Champ de Laparotomie Amélioré

UNE table de chirurgien très avantageuse peut être obtenue en incorporant deux plaques de métal dans un grand champ de laparotomie ordinaire.

Le champ de laparotomie, en usage à notre hôpital, mesure 8 pieds de longueur par 5 pieds et trois pouces de largeur. Au centre de sa largeur, une ouverture de 6 pouces de largeur par 10 pouces de longueur est taillée à 2½ pieds de la tête du champ. Deux chemises de 15½ pouces de largeur par 11½ pouces de longueur sont obtenues en cousant deux pièces de coton à la partie inférieure du champ, près de l'ouverture centrale.

La plaque de métal de 15 pouces de largeur par 11 pouces de longueur est en aluminium de 1/32 de pouce d'épaisseur. Les coins sont arrondis et une bordure de ¼ de pouce est repliée en dessous pour rendre les plaques plus rigides et ses bords plus lisses (fig. 1). Les plaques de métal sont glissées dans les chemises et fixées par deux galons. Le champ est replié par dessus l'ouverture centrale et une marque indique quelle partie doit être placée vers la tête.

Le champ est d'abord déplié de chaque côté de la table, puis la partie supérieure et, finalement, la partie inférieure avec les deux plaques. Il peut être très facilement déposé sur le patient avec une technique aseptique parfaite. Pour déplier la partie inférieure du champ contenant les deux plaques, la partie de ce champ, voisine des plaques ou correspondant au bord inférieur de l'ouver-

Figure 6



4. *The special laparotomy sheet as applied over a patient.*
   Champ de laparotomie modifié tel qu'il est déposé sur un malade.
5. *The surgeon's table provided by the sheet.*
   Table de chirurgien, telle que formée par le champ de laparotomie.
6. *The folded sheet with the two metal plates.*
   Le champ de laparotomie plié, contenant les deux plaques.

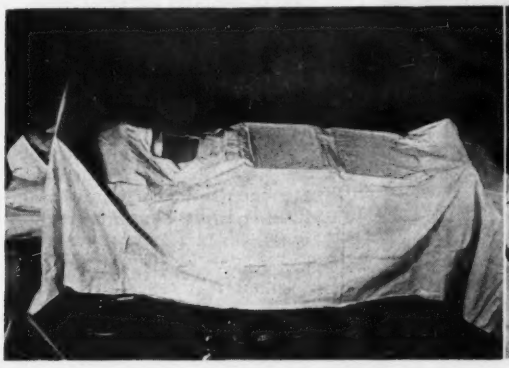


Figure 4



Figure 5

ture centrale, est tenu bien tendue et un peu abaissée de chaque côté de la table. Cette petite manœuvre permet de déplier facilement cette partie du champ contenant les plaques, les plaques tombent bien en place et le reste du champ ne se déplace pas (fig. 2 et 3).

Ce champ de laparotomie modifié offre les avantages suivants:

Il forme une table de chirurgien très avantageusement placée à quelques pouces du champ opératoire. Les plaques restent parfaitement bien en place par leur poids et la friction normale du champ (fig. 4 et 5).

Les plaques de métal, stérilisées avec le champ, assurent une aseptie parfaite même sans autre recouvrement qu'une simple épaisseur de coton. Cette partie du champ peut être imbibée de soluté, sang, exsudat, pus, sans danger de contamination par capillarité par en dessous.

Cette table de chirurgien, d'environ 24 pouces de longueur par 15 pouces de largeur est plus grande que la table ordinaire. Elle est au même niveau que le champ opératoire. La plaque inférieure est habituellement légèrement penchée vers le bas. Cette légère inclination n'est cependant pas suffisante pour faire glisser les instruments et accessoires. Un bon nombre d'instruments et accessoires quelque peu encombrants, tels que écarteurs, appareils à suction, et bassins réniformes, peuvent facilement être placés sur la table (fig. 5).

La technique du service opératoire et son équipement sont simplifiés parce qu'il n'est pas nécessaire de placer une table sur le patient avant d'installer le grand champ de laparotomie.

Le patient et ses couvertures non stériles, tels que drap et couverture, sont protégés et beaucoup moins facilement souillés par les solutés, le sang, les exsudats, et le pus.

Il suffit de quelques secondes pour placer ou retirer les plaques de métal et le champ de laparotomie peut être lessivé, stérilisé, plié manipulé tout aussi facilement qu'un champ de laparotomie ordinaire (fig. 6).

Dans certaines circonstances, par exemple si le champ de laparotomie est placé vers le bas de la table d'opération ou sur un jeune enfant, la plaque inférieure ou les deux doivent être enlevées. Ceci peut se faire facilement avant que le champ soit placé sur le malade ou au moment où il est déplié (fig. 7).

Nous n'avons vu nulle part ce genre de champ de laparotomie et nous croyons que notre conception est originale. Cependant, aucune recherche spéciale n'a été entreprise pour savoir si la même idée n'a pas déjà été exposée.

Nous avons utilisé ce champ de laparotomie pour une grande variété d'opérations et il s'est montré très utile.

Figure 7



7. The metal plate can be slipped out aseptically as the sheet is applied.
Le plaque de métal peut être facilement enlevée aseptiquement pendant que le champ est placé sur le malade.

New Lakehead Council

A new organization, which is to be known as the Lakehead Hospital Council, was formed at a meeting, held at the McKellar General Hospital, Fort William, Ont., early in October. Hospital superintendents and other senior officers from the Fort William Sanatorium, McKellar General Hospital, the Port Arthur General Hospital, and St. Joseph's Hospital, Port Arthur, Ont., were in attendance.

Realizing that greater efficiency would be gained in caring for the sick and injured by improving hospital administration techniques, the Lakehead Hospital Council was created to advance, wherever applicable, standards of hospital administration. The purpose of the organization will be carried out in the following way:

(a) Through holding regular monthly meetings for members to discuss problems and work out solutions for the betterment of Lakehead hospital services.

(b) Through the compilation of useful data accumulated as a result of the work of members.

(c) Through strict adherence to the code of ethics of recognized hospital associations to encourage high standards in the profession of hospital administration.

(d) Through the active participation of members to encourage the development of new ideas and the publication of articles by the members in the professional journals and other media.

Regular monthly meetings will be held on the first Wednesday of each month and copies of the constitution are available on request.

Officers

President: Douglas R. Peart, Administrator, Port Arthur General Hospital, Port Arthur.

Vice-President: Sister Felicitas, Superintendent, St. Joseph's Hospital, Port Arthur.

Secretary: Sister Jane Francis, St. Joseph's Hospital, Port Arthur.

Budget Time

Part II

The Mechanics of Budgeting*

Robert M. Clements,
Accounting Consultant,
Hospital Administration and Standards,
Dept. of Public Health (Sask.),
Regina, Sask.

IN the Budget Time article last month I explained what a budget is, what it looks like, how much work is involved in the preparation, what useful purpose is served, and what you should do by way of preliminary preparation to be ready to start right in on the budget as soon as you have read this instalment.

The hospital budget is divided into three main parts, the hospital work program, the income and expenditure estimates, and the explanations. The work program summarizes the activities of each department for the current period, and estimates the activities for the coming year. It also explains the reasoning behind the estimates. In this part of the budget you list the number of patient days broken down into private, semi-private, standard ward and newborn, and the number of out-patient visits; showing the actual count for the period which has just been completed and the estimate for the coming year. In estimating the patient days you consider the trend during the past few years, the size of the waiting list at various periods, the number of beds that will be set up in comparison with the numbers over the period that has passed, any major epidemics or disasters that have occurred in the past and which you don't expect to occur during the coming period, the staff that will be available for bedside nursing, anticipated changes in the student nurse enrolment, realocations in hospital space, additional facilities provided, and so on. You may even study changes in the population of the area served by the hospital or probable changes in the boundaries of the area due to the opening of new hospitals or additional beds in existing hospitals or the shift in area boundaries due to changes in hospital medical staff. As a rough guide, the number of beds set up should approximate the official rated capacity of the hospital, the occupancy in the various classes of accommodation should be about 80% based on beds set up, about 3.2 hours of bedside nursing care should be provided per in-patient per day, roughly 1.9 hours by graduate nursing staff and 1.3 hours by other nursing personnel. However, these rough rules will vary with local conditions. The percentage occupancy of beds set up, and even the number of beds set up, will depend to a large extent upon whether or not the floor areas provided for beds in the hospital are inadequate for the needs of the community, sufficient for the needs of the community, or in excess of the needs of the community.

The volume of service to be rendered by each department should be estimated in the same manner as the volume of patient days. In the operating room an estimate should be made of the number of major and minor operations, in the delivery room an estimate of the number of confinements, in the laboratory an estimate of the number of procedures, in radiology the number of x-ray plates and the number of treatments should be estimated, in physiotherapy the number of treatments, and in any other professional care department the volume of service should be considered.

The estimates of volume of service in the professional care departments should be reflected in the estimates of the administration and the general service departments. In the general administration, the general effects of any changes of personnel policies, purchasing policies, collection policies, and the policies concerning fund-raising campaigns, should be considered.

The general effect of labour-saving devices should be noted in the hospital work program, the research program for the coming year should be outlined, and the work program should contain particulars of the general building maintenance program, including painting and decorating. Any anticipated changes in grants, donations, or ancillary services should be explained.

Income and Expenditures

After the tentative work program has been drawn up, the revenues and expenditures for the current period should be listed, and estimates for the budget period should be filled in item by item. Normally the budget sheets are headed up with six vertical columns for the expenditures and eight columns for the income. In the income portion, column 1 shows the name of the item, column 2 the number of units during the current period, column 3 the average revenue per unit during the current period, column 4 the total revenue for the item during the current period, column 5 the estimated number of units for the budget period, column 6 the estimated income per unit for the budget period, column 7 the total estimated revenue for the item for the budget period, and column 8 the reference letter corresponding to the letter under which the explanation occurs in the explanation section of the budget.

In the expenditure portion of the budget, column 1 shows the name of the item, column 2 the actual expenditure during the

(Continued on page 86)

**This is the second in the series of three articles. The first article "Should You Bother With a Budget?" appeared in the October issue of the Journal, and the third article "Sticking to Your Budget" will be printed in the December issue.*

Food and Its Service

Sponsored by
The Canadian Dietetic
Association

For a Christmas Joyful

Sister Frances Eleanor,
Director of Dietetics,
Halifax Infirmary,
Halifax, N.S.

SICK at Christmas, in a hospital, away from home—what a dreary prospect it might be. For home at Christmastide more than any other time unfolds its true meaning. Hence radiates that "peace on earth" announced by the celestial choirs at the birth of the Christ Child; hence stems the giving and the sharing of cheerful Christmas greetings on everybody's lips which makes the whole world friends.

To bring "the home" into the hospital, especially on Christmas Day, is *your challenge*. Since the spirit of Christmas is one of giving, the hospital staff should offer its best in material and talents. To hear patients say that they never had a happier Christmas than the one in your hospital proves your efforts have been a success, and brings its own personal reward, for:

"The heart grows rich in giving,
Self-contained, its strength sinks low;
It can only serve by loving,
And, by serving, love will grow."

May some of our traditions and suggestions be as jewels in the crown of your patients' happiness!

Christmas carolling by student and staff nurses is eagerly awaited by patients and staff alike. The Christmas story, old yet ever new, when told in song, strikes a responsive note in every heart.

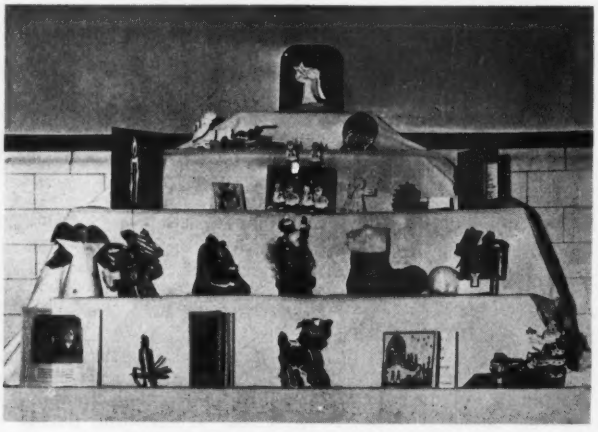
A decorated Christmas tree gracing every floor, individual festive wreaths of spruce or holly adorning each patient's door and window, miniature trees in rooms and wards, the usual white frosted electric bulbs replaced by soft greens or warm reds, halls bedecked with spruce and pine, the Crib in a prominent place—all these provide a warmth and glow throughout the hospital, and echo peace in our souls and good will to everyone.

To bring Christmas to the tray of the patient is a joyous, easy task. Certain food items are traditionally "Christmas". Just a few added trimmings make the patient know you are wishing him Merry Christmas, and meaning it.

Breakfast seems the appropriate time to convey to the patient the greetings of the hospital. This can be done by using favours of the cut-out type such as singing choir boys, angel silhouettes, the Bambino in the manger, or a decorated card with a short suitable verse. Ideas for such figures can be had in abundance from magazines, Christmas cards and tags, and even from Christmas wrapping paper. Special calenders, booklet type, with a picture of the hospital on the front, suitable verses on the two inner pages, and the calender on the last page have proved more than popular with the sick "guests" in our hospital. These can be used on New Year's Day, if so preferred.

Fruit cups, grapefruit halves or baskets, garnished with red and green cherries, topped with a piece of spruce or holly, and a red or green bow, give color to the tray. Red or green paper doilies may be used under the fruit. Crisp parsley on ham and paprika on eggs add just the right touch of yuletide colour.

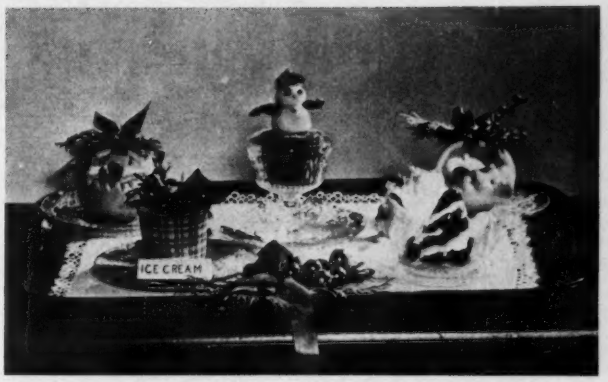
Christmas dinner should be the event of the day. A printed dinner menu on a chubby Santa, a perky lamb, a Christmas tree or a decorated card is a cherished souvenir of Christmas dinner in the hospital. Candles, symbolic of Christmas, are decorative as well as meaningful. There are many ideas



Favours, menus, decorations brighten meals at Christmas time.

for candle favours. Here are two of them.

Remove the outside wrapper from a package of life savers. Cut two circles of red cardboard about two and a half inches in diameter. In the centre of one, put a small amount of mucilage and stick it to one end of the package of life savers. Cut a hole from the centre of the other exactly the size of the circumference of the life savers. Slip it over the package until it is about one half inch from the other red circle. This forms the candle holder. Cut two small flames from yellow or gold paper. Paint the centre of the flame with red poster paint. Paste these two flames together over the end of a toothpick, and push the end of the toothpick through the tinsel of the life savers until it rests on the top. Now you have the finished product—a silver candle in a red candle-holder. A handle for the holder may be made from the silver paper from x-ray film or a three-inch strip of red cardboard, one quarter inch wide, curved in two and fastened under the life savers to the first red cardboard circle.



And they taste good, too!

A very attractive but simple novelty can be made by sticking a red or green birthday cake candle in a large gumdrop. A life saver tied to the side of the gumdrop with narrow ribbon supplies the handle for the candlestick.

Life savers also make an excellent yule log when tied atop a red cardboard sleigh. Another sleigh pattern provides space for a cellophane-wrapped bundle of candy with Santa riding in the back.

Garnishes and appropriate molds Star-shaped cranberry jelly, snow enhance the menu immensely. men of hard sauce, name tags of your favorite cookie recipe or Christmas tree salad add a party note to the meal. The latter item is especially simple and attractive. Just add a little more green coloring to lime jello, and make a fruit jelly with a plump red maraschino cherry here and there in the mixture. Mold this into cone-shaped paper drinking cups. When set, remove the cup and place the jello on a bed of shredded lettuce, and swirl garlands of whipped cream around it with the pastry tube. The red cherries gleam through the jelly like tree ornaments. The result is a shimmering, edible tree.

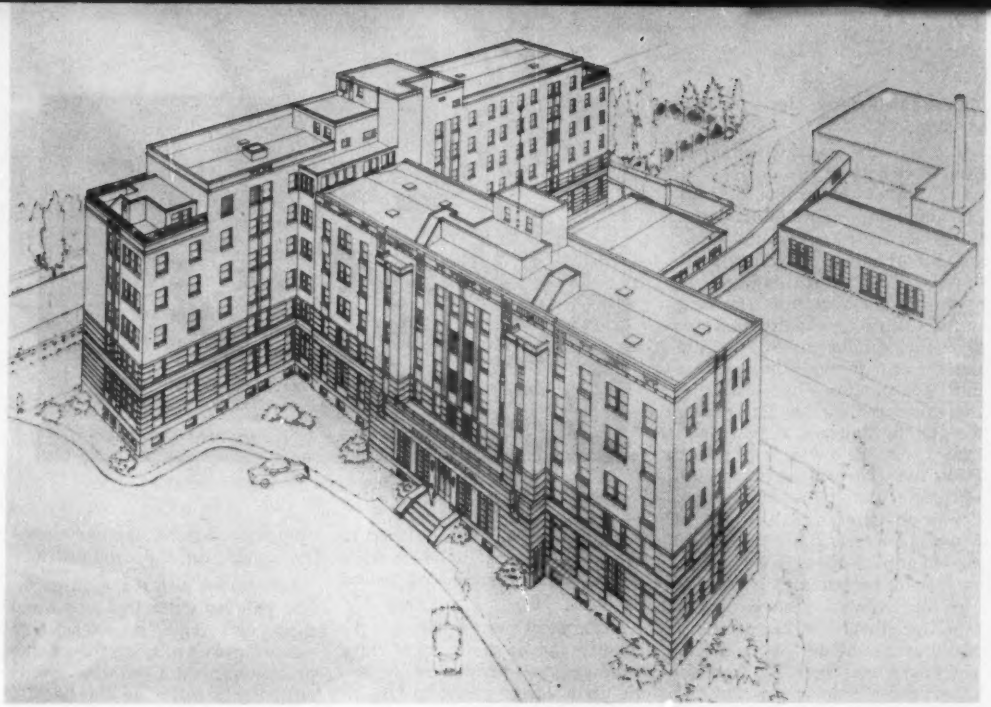
Such garnishes as mint leaves, green or red cherries, gumdrops, pimento, citron, and angelica can produce endless varieties of decoration and give much eye-appeal to the simplest dish.

The best recipe for success in giving your hospital a happy, homey atmosphere is imagination or creative ability plus a dash of patience and many ounces of genuine love for people, that

(Concluded on page 92)



Everybody likes a gaily decorated Christmas tree.



Extension to the Edmonton General

Hospital Founded by the Grey Nuns in 1895

Pictured above is the architect's sketch of the present expansion program which is under way at the Edmonton General Hospital. In the foreground is the main central section which was built in 1940; adjacent to this is the new seven-storey east wing; and the new one-storey kitchen service wing adjoins both. Other existing units are not shown here.

Built of reinforced concrete with clay tile fillers between concrete joist, the two lower stories of the new wing are of dark "rug" brick made locally, while the upper stories are faced with light cream imported terra cotta brick. The dark brick will be used on the two lower stories of the main building and on the kitchen wing. The estimated cost is $2,000,000, exclusive of equipment and furnishings.

It is expected that the additions will be completed next year. George Heath MacDonald, of Edmonton, is the architect.

EXCAVATION work was begun in 1950 on the new 200-bed east wing of Edmonton's first hospital—the General. That year marked the 55th anniversary of the hospital's founding in 1895 by the Sisters of Charity d'Youville, better known as the "Grey Nuns".

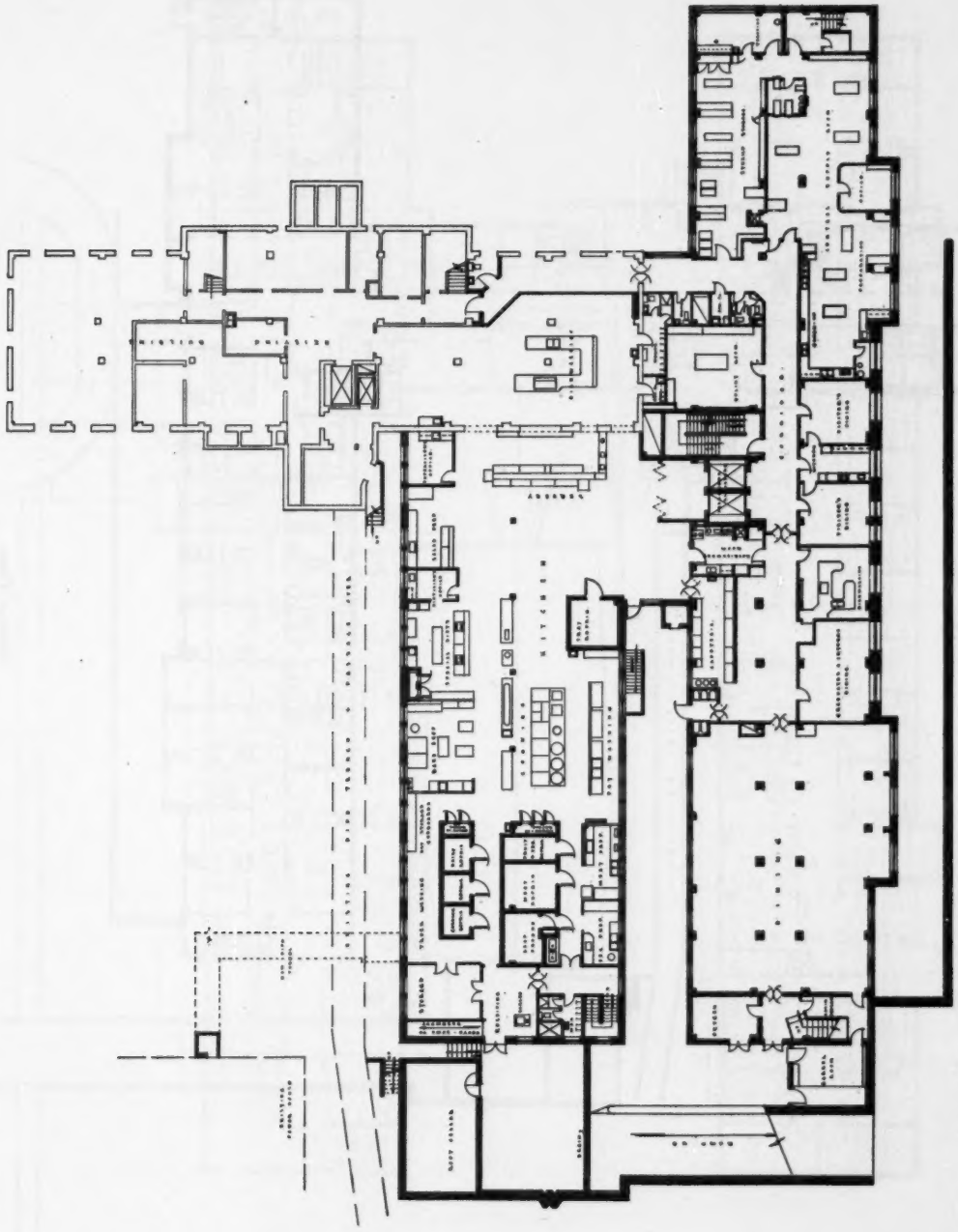
Beginning with a 36-bed hospital, the capacity of the General had increased to 200 by 1928, and a 100-bed unit (main section above) was erected in 1940. Keeping pace with the rapid growth of Edmonton, the new addition will again place the General among the finest and most modern hospitals west of Winnipeg.

With an envious record of achievement, the hospital has turned out more than 900 nurses in over half-a-century of service, and there are currently some 150 students in the School of Nursing. By way of contrast, the first training school for nurses was begun in 1908; and the first class of six pupils graduated in 1911.

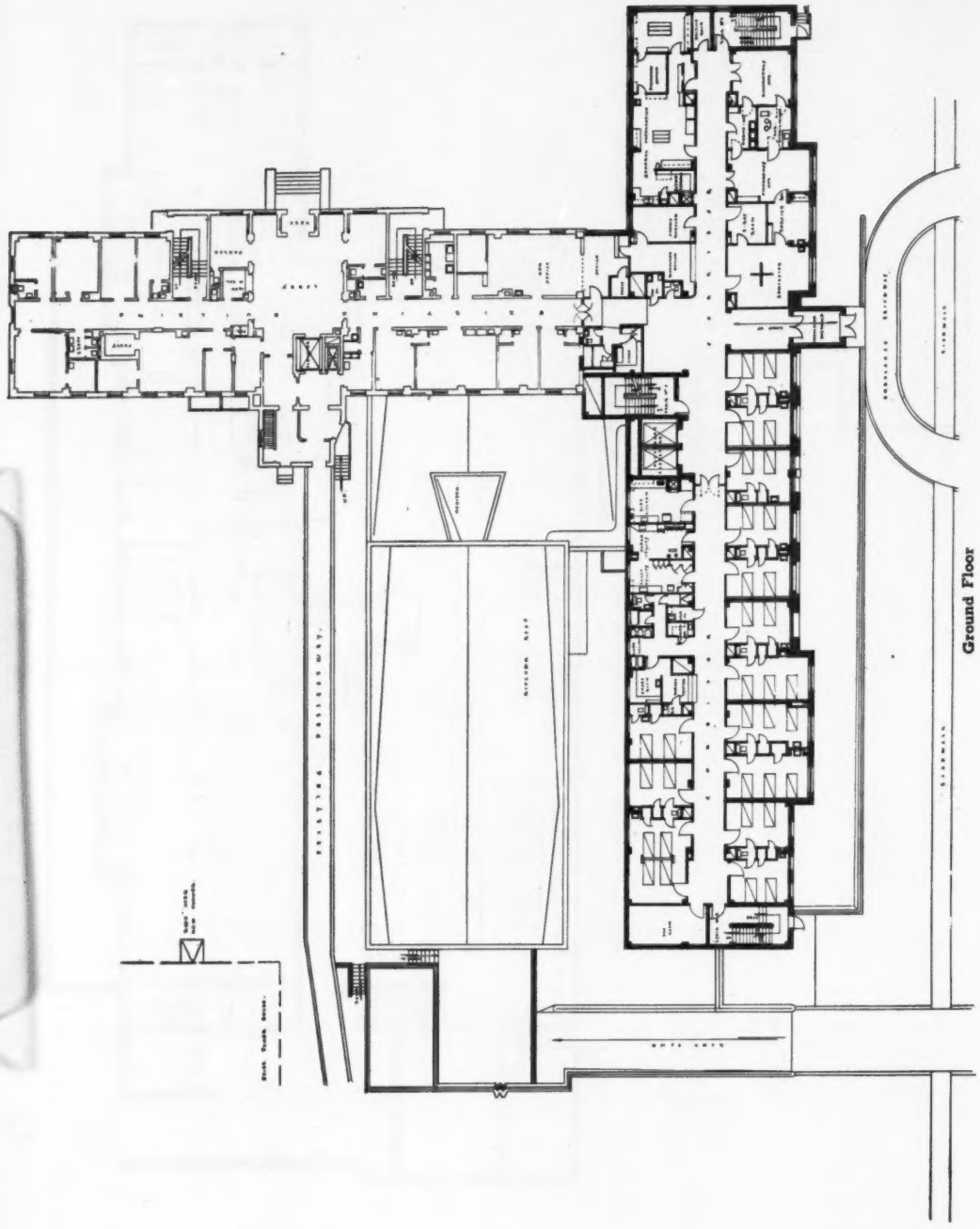
In its early history, the hospital was ably assisted by its lay auxiliary, the Ladies Aid Society, founded on December 21, 1895, "to give assistance to the hospital". This was accomplished through gifts, donations, proceeds from "charity bazaars", et cetera. The society was disbanded 10 years after its inception. However, in 1949 it was re-established, its constitution revised, and its name changed to the Edmonton Hospital Auxiliary.

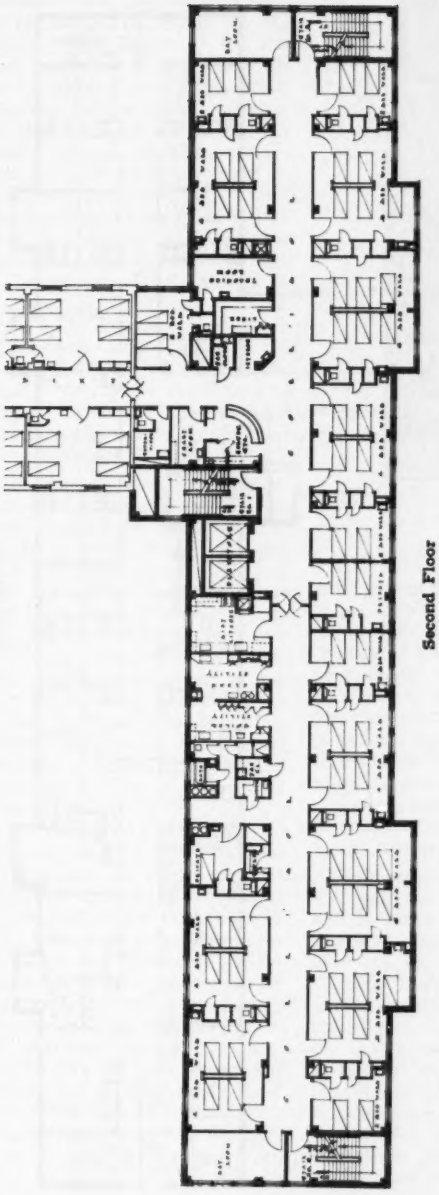
The Edmonton General Hospital was born against a colourful pioneer background. The population of Edmonton was then 1,600 and in the surrounding districts there were some 15,000 people,

From an article by John Patrick Gillese, September, 1950.

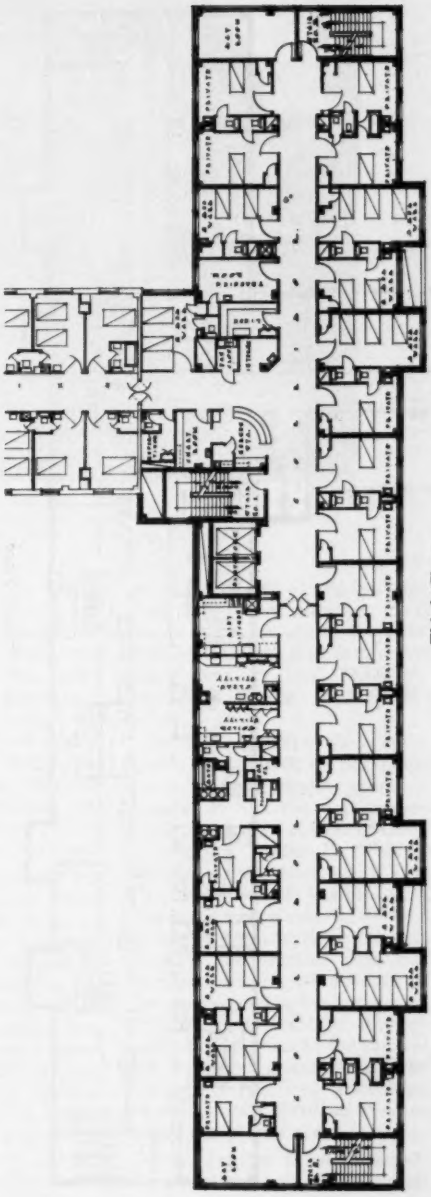


Basement Floor

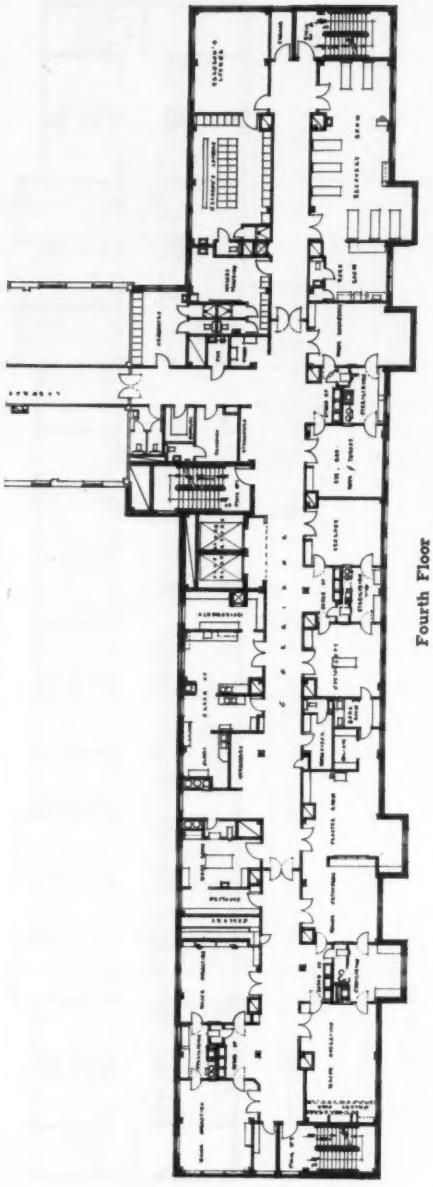

Ground Floor



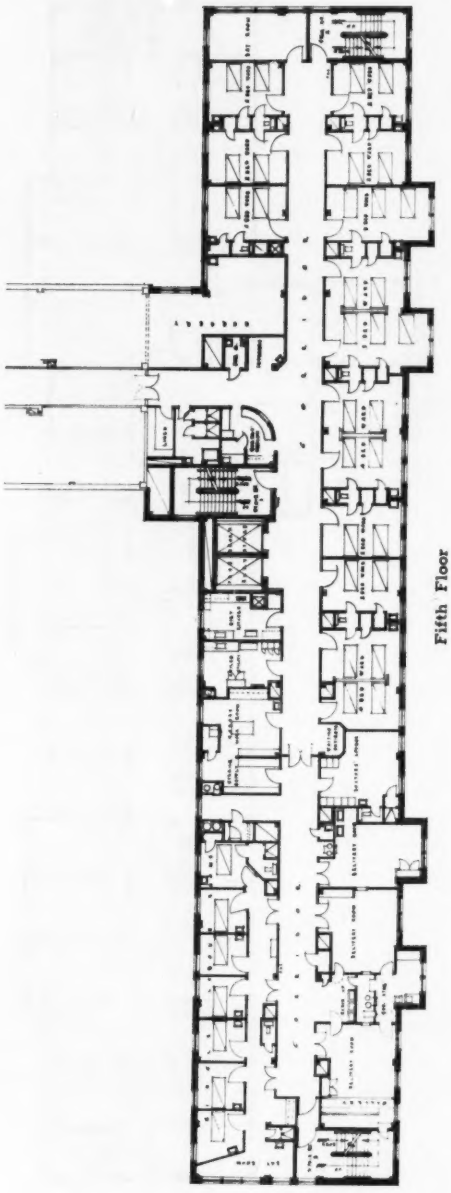
Second Floor



Third Floor



Fourth Floor



Fifth Floor

comprised largely of Indians and half-breeds. At the time, the only hospital building in Central Alberta was a frame structure 80 by 40 feet, with a projection in front 20 by 40 feet, adjoining the old mission of St. Albert. It, too, was built by the Grey Nuns who made the trip on foot from St. Boniface, Manitoba, to the unmapped west. In the town of Edmonton, six young doctors, whose names are now part of local history, saw urgent need for a hospital in what was to become the capital city of Alberta. In May, 1894, "we the undersigned doctors of the Village of Edmonton"—H. C. Wilson, H. L. McInnes, P. S. Royal, J. A. Tofield, J. D. Harrison, and E. A. Braithwaite—sent a letter to His Lordship, Bishop Grandin, promising to "do all in our power to support a General Hospital which would be constructed by the Grey Nuns in the Village of Edmonton".

On July 28th, 1895, Sister Marie-Xavier and Sister Gosselin arrived to draw up the plans. For two months they lived in a shack, with cots for beds and empty nail kegs for chairs. Six other Sisters arrived in December, when Bishop Grandin blessed the new building—a notable milestone in the historic development of Edmonton. A newspaper account of the day describes Edmonton's first General Hospital as "the largest, the most beautiful and the most expensive building in Edmonton".

Some idea of the courage and vision needed for the hospital's founding can be gathered from the fact that in 1891, when Dr. Braithwaite returned to Edmonton as staff doctor to the R.N.W. M.P,, there was no doctor between Red Deer and Edmonton and between St. Albert and the arctic. "Alberta", destined to become a province in 1905, existed only as an unnamed part of the vast North-West Territories; and against that frontier background, Doctors Harrison and Braithwaite achieved some sort of immortality when an Indian messenger arrived from Stony Plains, indicating they were needed on an emergency case. "Bush burns!" was the only English the runner knew, and the doctors concluded that their unseen patient needed some sort of treatment for burns. When they had travelled the 20 miles, they found, instead, that the farmer had got the worst of a neighbourly quarrel — his head was bashed in by a fence rail. The Indian's "bush burns" referred to the forest fires raging through the bush and forest surrounding the old town. Happily, the young doctors improvised sufficiently, so that the farmer lived to the proverbial "ripe old age".



Construction under way, showing erection of sixth floor paediatrics department, plan of which is not included here. Pent houses will rise above.

Numbered in the thousands are the patients who owed their health, limbs and even lives to the great corporal work launched 55 years ago by the Sisters of Charity. The first patient was admitted to the General Hospital on the 17th of December, 1895. During that month 31 patients were treated in all. By 1907, a new four-storey addition and a new laundry were added to the hospital. In 1916, Sister Gosselin who, with Sister Marie-Xavier, opened the hospital, became the General's first Superior. By 1935, 71,710 patients were cared for; 23,665 operations performed; 5,105 babies were brought into the world, and more than 10,000 children had received the benefit of hospital care. Since then these numbers have grown in proportion to the great development of Edmonton and district and, by 1950, 83,185 patients had passed through the hospital's doors.

The new addition to the hospital reflects the growth of Edmonton into one of the major cities of Canada. It is a living testimony to the work of the Sisters of Charity founded October 30, 1738, by the Venerable Madame d'Youville, a native of Quebec who, after her husband's death, devoted her life to ministering to the sick. Through the terrible smallpox epidemic of 1870, which claimed almost one-third of the population of the Edmonton district, through good times and bad to the present day, the quiet, unassuming Grey Nuns have endured hardships, privations and difficulties to serve the people of this area.

At present, Dr. Kenneth Hamilton, who has served the hospital for 20 years, is president of the staff, and Sister Alice Herman, who has been with the General since January 1947, is the Superior.

33rd Annual Convention of the Saskatchewan Hospital Association

Hospital Viewpoint in Saskatchewan

SOME two hundred delegates from all parts of Saskatchewan gathered in Regina as the Saskatchewan Hospital Association held its 33rd annual convention on October 11th and 12th.

The convention opened with an invocation by Rev. Father Hector L. Bertrand of Montreal; and a warm welcome to Regina was extended by Mayor G. N. Menzies and Dr. George Walton of the Regina and District Medical Society.

In his presidential address, H. H. Bassett of Prince Albert reported that Association officials had enjoyed an active year. Seven official executive meetings took place and many other unofficial meetings were held concerning operation of the province-wide hospital insurance plan and other Association business. Mr. Bassett also gave delegates the highlights of the 11th biennial meeting of the Canadian Hospital Council, the convocation and meeting of the American College of Hospital Administrators, and the 53rd convention of the American Hospital Association in St. Louis, Mo., which he, Dr. H. E. Baird of Regina, and the Association secretary-treasurer, John Smith of Yorkton, attended.

In his secretarial report to the convention, Mr. Smith pointed out that there had been a substantial increase in institutional membership during the past year and that the Association was enjoying sound health, financially.

Dr. F. D. Mott, Deputy Minister of Health, presented an interesting account of the meeting of the assembly of the World Health Organization which was held in May of this year in Geneva, Switzerland. He attended as a member of the Canadian delegation.

Speaker's Parade

Sister B. Bezaire, St. Paul's Hospital, Saskatoon, very ably presented a paper in which she outlined the Catholic attitude towards the future of the voluntary hospital. Dr. G. G. Ferguson, Saskatoon, Registrar of the College of Physicians and Surgeons of Saskatchewan and Judge J. Milton George, Morden, Man., President of the Associated Hospitals of Manitoba, also addressed the convention. Murray Ross, Associate Secretary of the Canadian Hospital Council, reviewed the activities of that body.

A very informative lecture on epidemiology and the handling of communicable disease cases admitted to general hospitals was delivered by Dr. Angus C. McGugan, Superintendent, University of Alberta Hospital, Edmonton.

G. W. Myers, Regina, Executive Director of the Saskatchewan Hospital Services Plan, reviewed the plan's operation and described the efforts made to develop an equitable and satisfactory method of reimbursing hospitals for services rendered to beneficiaries of the plan. Since the plan's inception, three methods have been followed and it is felt that the present arrangement (see *The Canadian Hospital*, April, 1951, page 38) is proving itself most adequate.

That the introduction of the Hospital Insurance Plan had stimulated interest and public thinking in health matters was the view expressed by T. J. Bentley, Minister of Health. Mr. Bentley emphasized that the experience gained by the operation of the Saskatchewan plan was available and, in a number of instances, was being widely used by other provinces and agencies, without regard to political or any other considerations apart from a genuine interest in health progress. He also expressed satisfaction at the progress which had been made in providing an adequate number of hospital beds. He warned, however, that the quality of care available was not always regarded as satisfactory and that constant effort at improvement must continue. Everything which is done to improve or expand health services must be paid for and Mr. Bentley drew attention to the fact that the cost factor and economic ability to pay for services must be carefully weighed when planning.

Following Mr. Bentley's address, S. N. Wynn, Yorkton, reviewed the work of the provincial health survey committee, whose report is now being prepared.

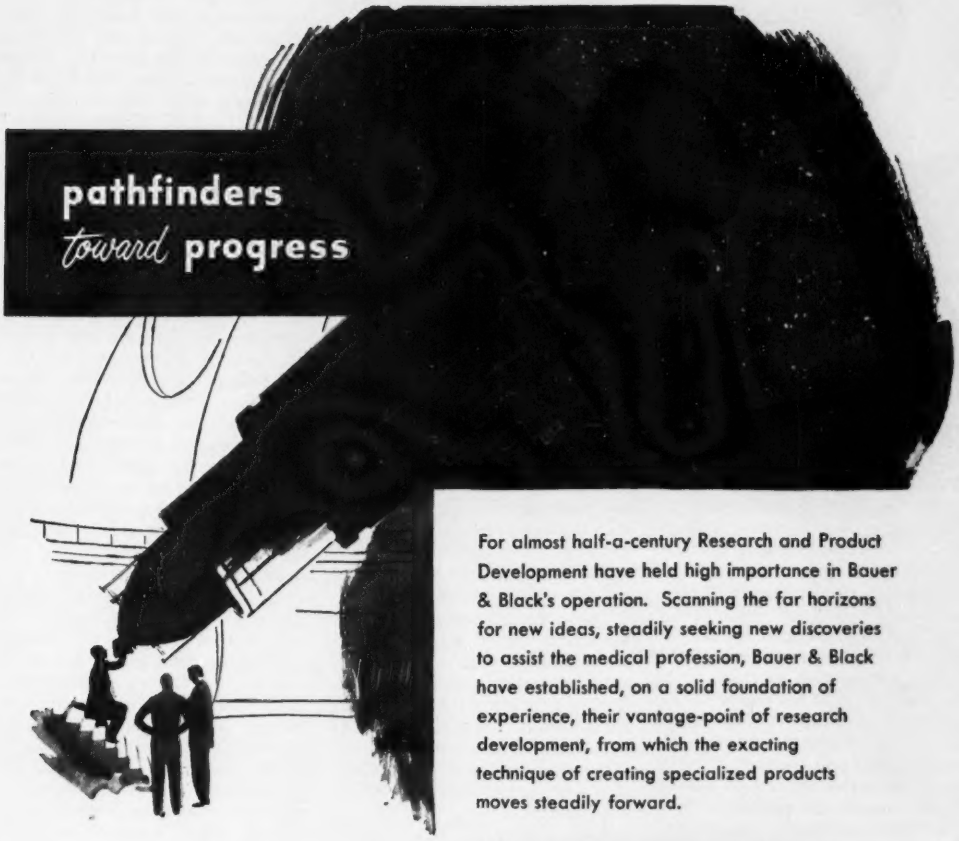
Dr. Owen C. Trainor, Winnipeg, president of the Canadian Hospital Council, briefly reviewed the Council's development. He expressed the belief that the Council had "reached its majority" and that it had proved to be invaluable to Canadian hospitals. Dr. Trainor warned delegates that Council financing was on thin ice in continuing to be supported by voluntary contributions of members and expressed, as a personal view, the thought that a more definite and business-like arrangement between member associations and conferences was overdue.

The development of the national blood transfusion service by the Saskatchewan Red Cross Society was described by Col. F. W. G. Miles, Commissioner. Mrs. W. B. Frost of Melfort, provincial president, addressed the delegates on the work of the Hospital Auxiliaries Association.

Dr. E. A. McCusker, M.P., Parliamentary Assistant to the Minister of National Health and Welfare, was guest speaker at the annual convention banquet. He gave an interesting review of the

(Concluded on page 108)

pathfinders *toward* progress



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34th Annual Convention of B. C. Hospitals' Association

Harmony the Keynote of B.C. Meeting

FOLLOWING two days of pre-convention lectures and discussions, the 34th annual convention of the British Columbia Hospitals' Association was held in the Hotel Vancouver, on October 18th and 19th. Over 200 delegates and visitors were welcomed to Vancouver by the acting Mayor, Alderman George Miller and the invocation was given by Rev. Father H. L. Bertrand, S.J., of Montreal.

The Hon. A. D. Turnbull, Minister of Health and Welfare for the province, pledged himself to fight for the preservation of the hospital insurance service and to do everything in his power to improve its operation. On the other hand, Mr. Turnbull warned administrators and trustees in grave terms that the amount of money which people are willing to pay for health services is limited and that further serious increases in hospital costs might well force abandonment of the government sponsored service. Referring to the Inquiry Board, established by the legislature at the last session, whose full report is expected before the next session, Mr. Turnbull mentioned that certain recommendations contained in an interim report are already being studied and put into effect.

Continuing the discussion of B.C.H.I.S., Lloyd F. Detwiller, Hospital Insurance Commissioner, outlined steps being taken to improve administrative efficiency in the plan's operation. The adoption of the firm budget plan, co-insurance, and other variations which have been introduced are improving the plan's stability, Mr. Detwiller reported. He emphasized the need for keeping the hospital a community organization and restated that it was the policy of the government not to interfere with the autonomy or local control of any hospital.

The harmonious spirit of the convention was emphasized in his presidential address by A. H. J. Swencisky who declared that the association would work in closest co-operation with the government and the insurance service in efforts to solve problems and to strive for improved hospital care for the people of the province.

The Association's Executive Secretary, Percy Ward, reported a very active year and a favourable financial position, despite certain difficulties which had been encountered. Reports to the Association were received from representatives of the Regional Councils and major divisions of the organization.

Among visitors from outside the province who participated in the proceedings were: Dr. Angus C. McGugan of Edmonton, past president of the Associated Hospitals of Alberta and first vice-president of the Canadian Hospital Council; Rev. Father H. L. Bertrand, of Montreal, president of the Catholic Hospital Council of Canada and second vice-president of the Canadian Hospital Council; Dr. D. F. W. Porter, of Moncton, past president of the Maritime Hospital Association; and Judge J. Milton George, K.C., president of the Associated Hospitals of Manitoba.



A. H. J. Swencisky

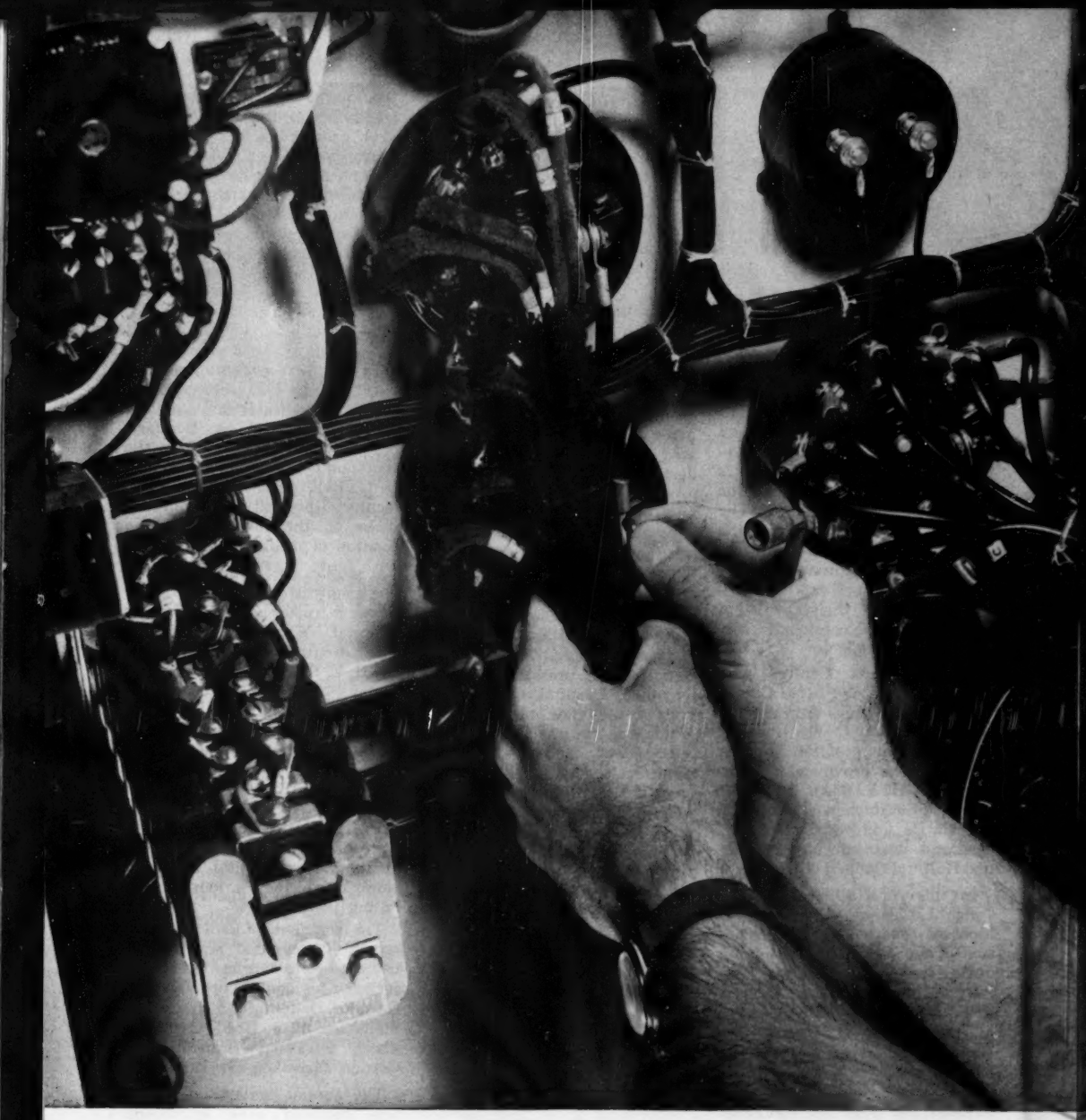
Dr. A. C. McGugan spoke on the purposes, obligations, and accomplishments of the Canadian Hospital Council and Murray Ross, associate secretary of the C.H.C., discussed the new two-year extension course in hospital organization and management now being sponsored by the Council. He also reported progress in the compilation of a standard Canadian hospital accounting manual, a project now well under way.

Graduate nurses of St. Paul's Hospital, Vancouver, under the direction of Ruth Brydon, Reg.N., gave a practical demonstration in the care of the premature infant. This demonstration was of particular interest coming as it did on the day following a lecture on child and maternal health, emphasizing the need for improved premature care, by Ruby Tinkiss, Reg.N., consultant in child health, Department of National Health and Welfare, Ottawa.

Pre-Convention Lectures

Other lectures preceding the convention proper were judged to be highly enlightening. Sister Columkille, of St. Paul's, Vancouver, president, B.C. Registered Nurses' Association, entitled her paper "The Tapestry of Nursing". Dr. McGugan sketched the highlights of his very complete analysis of the handling of infectious cases in general hospitals. New ideas being developed in hospital planning were discussed by H. Gordon Hughes, chief, Hospital Design Division, Department of National Health and Welfare, Ottawa. Interest was enhanced as Mr. Hughes cast on the screen schematic drawings and layouts to illustrate his lecture.

(Continued on page 94)



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30th Annual Convention of the Associated Hospitals of Manitoba

Record Attendance

CLOSE to 200 enthusiastic delegates registered for the 30th annual convention of the Associated Hospitals of Manitoba, held at the Marlborough Hotel, Winnipeg, on October 24 to 26. The record attendance, excellent exhibits, and varied program reflected credit on the Association's officers and on the spirit of the hospital people of Manitoba. The program committee, under the chairmanship of John M. McIntyre, and the executive secretary, Paul Shannon, merit special commendation for their work in arranging this exceptionally successful convention.

Mayor Garnet Coulter welcomed the delegates to the City of Winnipeg. Greetings were extended by the Hon. C. E. Greenlay, acting Minister of Health, on behalf of the provincial government, Dr. H. E. Baird, on behalf of the Saskatchewan Hospital Association, and Rev. Father H. L. Bertrand, on behalf of the Catholic Hospital Council of Canada.

In his presidential address, Judge J. Milton George, K.C., of Morden, reported on the expansion of the Association's program during the past year and the need for continued effort and interest if the needs of the hospitals were to be adequately met. Judge George advised of activities in neighbouring provinces whose conventions he had attended and stressed the need for continued co-operation between governments and voluntary agencies in order to meet the health needs of all citizens.

The report of Paul D. Shannon, executive secretary, indicated increased membership in the Association and reviewed specific activities in carrying out contractual negotiations, conducting accounting institutes, and assisting in the development of programs in the regional councils.

A very practical presentation by Dr. A. F. Menzies, of Morden, indicated many ways in which the economy of smaller rural hospitals could benefit from co-ordinated effort between hospital and doctor. Dr. Hugh Malcolmson, provincial director of industrial hygiene, dealth with hospitals and civil defence, recommending a close working relationship between rural and metropolitan hospitals.

Dr. Owen C. Trainor, chairman of the board of trustees of the Manitoba Hospital Service Association and president of the Canadian Hospital Council, expressed the view that the task of making hospital services, on a prepaid basis, available to all Manitobans could be done most economically through utilizing a voluntary carrier, preferably the existing machinery of Blue Cross. With government participation by insuring social assistance and indigent cases, Dr. Trainor predicted that the already high percentage of population coverage in Manitoba could be raised to an acceptable full-coverage level.

Under the chairmanship of Rev. Father Bertrand, the subject "Will we solve it now—or never?" (referring to the nursing problem) provided a very intensive morning. Miss E. A. Russell, director of public health nursing, explained the viewpoint of government, while Dr. F. A. L. Mathewson, Winnipeg, presented aspects which face medical staffs. Lillian Pettigrew, of the Manitoba Association of Registered Nurses, stirred up some controversial discussion with the suggestion that we are still trying to prepare 1951 nurses on a basic training method developed in 1900. Sister Berthe Dorais, superintendent of St. Boniface Hospital, St. Boniface, presented the problem from the standpoint of hospitals, and Dr. L. G. Bell, dean of the medical faculty, University of Manitoba, spoke on the subject from the position of medical educators.

A section on trusteeship, under the chairmanship of D. Bruce Shaw, a trustee of the Children's Hospital, Winnipeg, heard the scope of trusteeship described by Dr. H. E. Baird, of Regina. James Stefan, Assistant Professor in hospital administration, University of Minnesota, presented a very realistic review of what the administrator should expect from his board of trustees. Earl Murray of Neepawa, tackled the question as to whether trustees were keeping abreast of developments in the hospital field and emphasized the seriousness of failing to do so.

The comments of Paul Shannon, regarding increased regional activities, were borne out in a series of regional reports by John Gardner, Dauphin, P. F. Barkman, Steinback, R. J. Hood, Carberry, Frank Foster, Brandon and Gordon Pickering, St. Boniface.

The annual convention dinner was presided over by Judge George and the principal speaker was Dr. G. D. W. Cameron, Deputy Minister of National Health and Welfare, Ottawa. Dr. Cameron's concise address on the various phases of national health activities was not only interesting and informative, but, being presented in his usual easy and informal style, was much appreciated by his listeners.

O.H.A. Convention

As we go to press, the Ontario Hospital Association meeting is in full swing. This large gathering, including its seven sectional meetings, will be reported in the December issue, as well as the allied organizations convening at the same time.



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When gut is chromicized after strands are spun and dried, chrome concentration is very high in surface layers and relatively low in the core. Inner core is digested rapidly—the highly chromicized periphery survives for prolonged periods.



ETHICON TRU-CHROMICIZING

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***To illustrate this comparison, small laboratory trays are used. In commercial production, surface-chromicizing is done under tension. Both processes are performed in large vats.**

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Other Canadians Honoured at A.C.H.A. Convocation

Portraits shown here were not available in time for publication with our report on the convocation of the American College of Hospital Administrators last month. For complete listing, see October, pages 42 to 44.



Sr. Eugénie Choquette,
Montreal

A general session under Dr. W. R. Dunlop, superintendent of Deer Lodge Hospital, Winnipeg, dealt with the influence and effect of legislation, a subject very capably presented by Dr. E. R. Rafuse, provincial director of hospitalization. "Hospitals across the Nation", was the title of a symposium presented by Dr. G. D. W. Cameron, Dr. Owen C. Trainor, and Murray Ross, of the Canadian Hospital Council.

A. K. McTaggart, superintendent of Brandon General Hospital, Brandon, spoke on cost trends in a convincing fashion and R. J. Hood, of Carberry, dealth with the future of the "10-bed unit". Mr. Hood gave both sides of the question in respect to small medical-nursing units, indicating advantages in point of available services to rural communities and at the same time warning of the dangers of indiscriminate construction of units where adequate services were already available within reasonable distances.

At its business sessions the Association considered a number of resolutions presented by its resolutions chairman, Dr. O. C. Trainor. These dealt with the following:

1. The inadequacy of present financial arrangements for the payment of accounts of Indian patients.

2. Opposition to the extension of unemployment insurance coverage to employment in hospitals.

3. The decision to set up a study committee on nursing personnel.

4. A request that nurse placemment be included under the National Employment Service.

5. The suggestion that a business-like arrangement on a "per bed" or other equitable basis, be developed between the various member organizations for the adequate financing of the Canadian Hospital Council.

6. A recommendation that an

(Concluded on page 106)

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Prize-winning Public Relations Program

Putting Their Best Foot Forward

OF real interest and stimulus to the Canadian hospital field are the honours bestowed recently upon the Children's Hospital, Vancouver, B.C., for its excellent public relations program. In the contest sponsored by *Hospital Management* magazine, the Children's Hospital won first prize in the group of 200 beds or less and was awarded the Malcolm T. MacEachern Plaque which is pictured on this page. The award was presented during the annual A.H.A. convention held in St. Louis, Mo., and was received on behalf of the hospital by Murray W. Ross of the Canadian Hospital Council. The annual report of the Children's Hospital also received honourable mention in *Hospital Management's* Annual Report Competition.

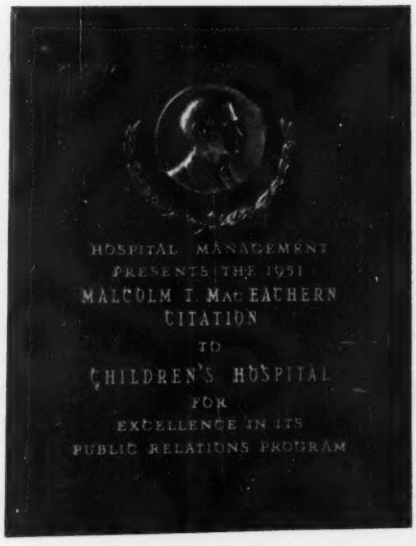
This recognition is indeed well deserved. The Children's Hospital has developed a public relations program that is wide in scope and highly effective in results. How does this hospital tell its story so well?

One of the annual features of this hospital's public relations program is the March of Dimes campaign. This idea was used at the Children's Hospital long before the March of Dimes became a national and yearly event in Canada. Originally, at the request of the hospital, the Vancouver Sun sponsored a campaign known as "March of Dimes for Children's Hospital" which was carried out at the same time as the American March of Dimes. By this means, the hospital could use a great deal of the material that was prepared by the American broadcasting companies. Now, this campaign is organized by the hospital and operated by the Women's Auxiliary Council. Various kinds of publicity material are sent to every radio station and newspaper in the province to be released in a certain order. Coin cards with spaces for ten dimes are distributed throughout the province by Vancouver Sun carrier boys. When the cards are full, the boys collect them and the one who turns in the largest amount is awarded an "Oscar"—a bicycle or some similar prize. Various unions and also the fishing fleets are approached through the distribution of circulars. Different communities throughout British Columbia organize their own "Dimes" campaigns and obtain public support by means of entertainment such as square dancing. Music lovers were also made aware of the needs of sick children, last year, when members of the Women's Auxiliary Council applied for and obtained permission to collect at opera performances and symphony concerts.

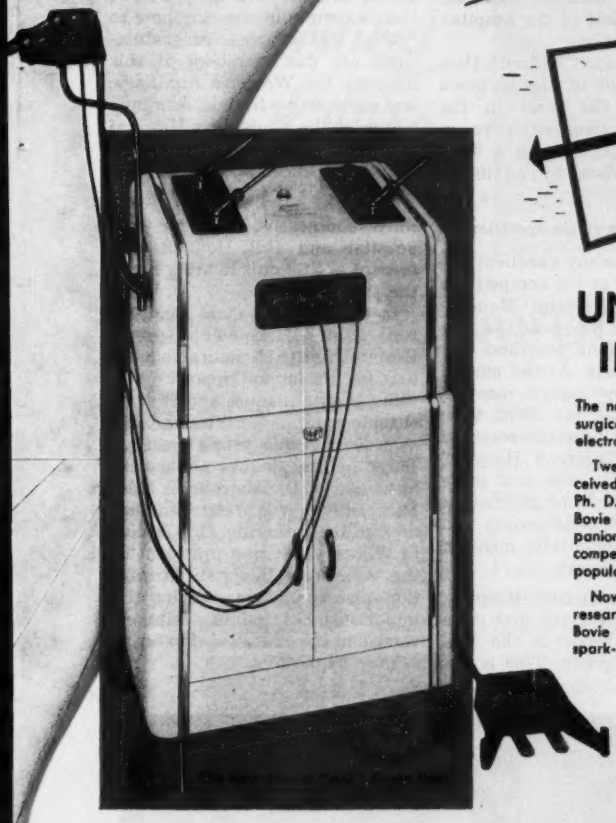
Besides this annual campaign, many other methods are used to keep the hospital in the public eye. The very ordinary action of lighting a match is of benefit to the hospital when people use the matches sold by the Council. The red, white, and blue books of matches depict two small children on the cover with the word "thanks" above. Over a two-year period this project has netted approximately $3,000 which is being used to purchase equipment.

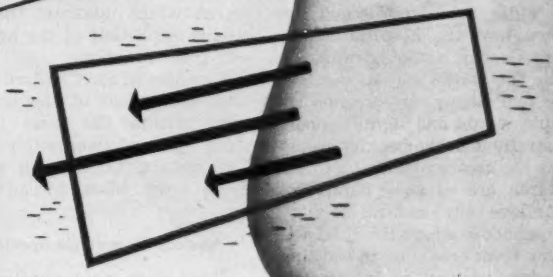
The celebration of an occasion such as National Hospital Day is not overlooked at Children's Hospital. Visitors are welcomed and literature of the pamphlet variety, outlining activities and progress, is available.

The Children's Hospital Society is another way of obtaining public interest and support. New members are being continuously solicited and old members are sent reminders to renew their membership. These forms point out the work being done by the hospital and show how the dollar membership fee helps the hospital in its care of sick children. Newsletters are sent out to members throughout the year to hold their interest and stimulate further support. Statistics are presened in readable fashion and members are presented with the latest informa-



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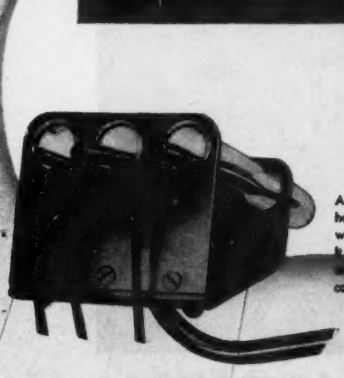
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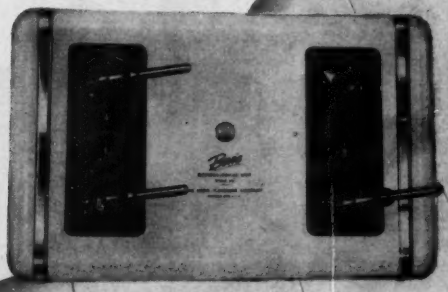
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(CANADIAN MADE X RAY EQUIPMENT)

tion on new equipment and methods in use in the hospital.

Of immense value to the parents of children in hospital are the booklets presented when a child is admitted. Parents are told exactly what their children will do while in hospital and are shown how the hospital staff is prepared to do everything to make the child's stay as comfortable and happy as possible. The simple words and light, amusing illustrations in the booklet are designed to assure parents that their children are in good hands and to relieve any natural anxiety. The schedule which the child will follow from breakfast to bed-time is given, as well as information about meals and special occasions, such as party days, Christmas, and birthdays. The parents learn how the child's schooling will continue during the hospital stay and what arrangements have been made for his recreation. The booklet also contains instructions concerning visiting hours, the best time to 'phone the hospital, the procedure when the child leaves the hospital, and follow-up care.

The grand finale of a hospital's public relations program occurs in the publication of its annual report. Here the activities and progress for the year are summed up for all to see. The Children's Hospital reports to the public in a very graphic and readable fashion. The report contains many story-telling pictures and an interesting presentation of facts and figures. The Women's Auxiliary Council also publish an annual report which tabulates their activities on behalf of the hospital, and their donations.

Members of the Children's Hospital are proud of the progress their hospital has made in the short span of twenty-five years. The hospital began with a little down town office, spread to an old frame house, and has now a modern building, 100 beds, and up-to-date facilities. At present, the Children's Hospital is preparing plans for an additional 100 beds. Such expansion of building, beds, and facilities necessitates public interest and support. For their example in showing how to obtain this support, congratulations are due members of this hospital, the Women's Auxiliary, and other active friends. Administrator of the Children's Hospital is H. P. J. Gunn, and the Public Relations Officer is Jean Pearce.

* * *

Annual Report Competition

There were many excellent entries this year in the competition sponsored by *Hospital Management* magazine to choose the best in public relations programs and in annual reports. At the annual public relations award meeting held in St. Louis, Mo., Sept. 16th, three Canadian hospitals received awards. The Children's Hospital, Vancouver, B.C., won first prize for its public relations program in the "under 200 beds" group and also received honourable mention for its annual report.

The Oshawa General Hospital, Oshawa, Ont., received first prize for its annual report in the "under 200 beds" group. This is the third consecutive win for this hospital and Bill Holland was present at St. Louis to bring home the award.

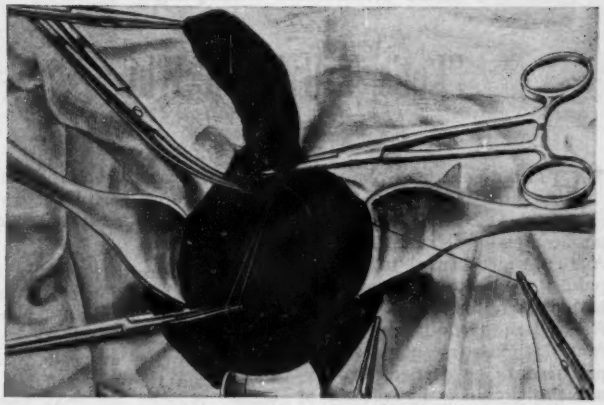
In the group of more than 400 beds, the Vancouver General Hospital merited honourable mention for its annual report.

Six bronze plaques and 26 honourable mention certificates were awarded at this year's meeting. Three of the plaques are named in honour of Dr. Malcolm T. MacEachern who was present and addressed the gathering. Dr. Charles F. Wilinsky, retiring president of the American Hospital Association, also spoke, emphasizing the importance of public relations work and the educational value of such a competition.



Some of the winners in the Hospital Management competition, left to right: C. E. Wonnacott, Dr. W. H. Groves Latter-Day Saint Hospital, Salt Lake City, Utah; W. A. Holland, Oshawa General Hospital, Oshawa, Ont.; Ralph Hueston, Wesley Memorial Hospital, Chicago; Dr. Malcolm T. MacEachern; Murray Ross, accepting for Children's Hospital, Vancouver, B.C.; Dr. A. F. Branton, Baroness Erlanger Hospital, Chattanooga, Tenn., and his assistant, A. M. Heyberger.

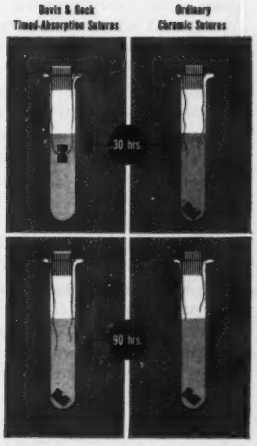
During the critical first 4 days depend on



"TIMED-ABSORPTION" CATGUT

Because "timed-absorption" catgut (surgical gut) has a *measurable* and *predictable* rate of digestion, demonstrated by extensive tests, it remains intact until the wound has gathered support of its own. Because "timed-absorption" catgut does not digest prematurely, it assures strength when needed most—during the critical first 4 days following major surgery.

Processed by an exclusive Davis & Geck method embodying accurately graded degrees of tanning, "timed-absorption" catgut has an absorption curve that parallels the changing tissue conditions of healing. Resistance to digestion is maximal during *early* repair. Later, when artificial strength is no longer required, dissolution is rapid and complete and no remnants of gut remain.



Comparison of D & G "timed-absorption" medium chromic catgut, size 0, with ordinary medium chromic size 0 catgut. Both types of catgut are suspended in a trypsin solution and weighted. Note that at the end of 30 hours D & G "timed-absorption" catgut remains intact; the weight is still held suspended up to 90 hours. Contrast with an ordinary chromic catgut suture which has begun to digest and breaks under the slight tension created by the weight at 30 hours. In human tissue all chromic sutures are digested *more slowly*, but the ratio between the two types remains the same.

D & G catgut sutures have a special matte finish. They tie readily and do not slip at the knot. Pliability is exceptional and tensile strength, diameter for diameter, is guaranteed unexcelled by any other brand. No wonder so many surgeons agree on D & G.

There is a D & G suture for every surgical purpose. Available through responsible dealers everywhere.

DAVIS & GECK, INC.

57 WILLOUGHBY ST., BROOKLYN 1, N. Y.

O. H. A. Public Relations Campaign

"Let's Tell Them Why"

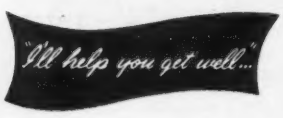
WITH this catchy phrase as a title, the Ontario Hospital Association launched a public relations campaign last August which aimed to tell the public why hospital costs are higher today than ever before. At Association headquarters in Toronto, stimulating material was prepared to be carried throughout the province by means of radio, sponsored newspaper advertising, news releases, and public addresses. All details of the program were made available to the superintendents of member hospitals and their aid was enlisted in order to make the campaign successful in the individual community.

Radio

Radio transcriptions were an excellent public relations tool. The Association provided these dramatized, 15 minute transcriptions for use on local radio stations. Produced by the American Hospital Association, the transcriptions offered a variety of subjects such as, introducing your hospital, hospital costs and administration, obsolescence and expansion, as well as interesting descriptions of various hospital departments. The use of these programs by independent stations on a public service basis was endorsed by the Canadian Association of Broadcasters.

Newspaper

Four eye-catching, informative advertisements (see illustrations on this page) were prepared by the O.H.A. and were available to hospitals in matrix form on a "share the cost" basis, the hospital's portion being $15 for the set of four. It was the administrator's task to interest local businessmen in sponsoring the advertisements in newspapers.



Bearing arresting titles and illustrations, this clever advertising told the hospital's story in words and examples easily understood by the average reader. "Who said they've seen an iceberg!" pointed out that just as seven-eighths of an iceberg is under water and hence unseen, so also in a hospital there are hosts of people working for the health of the community who are unseen by the average patient or visitor. Hospitals do not display much of



what they do for the sick of the community, thus, the advertisement concludes: "We, as citizens, owe a great deal to these non-profit public institutions which, in the face of inflationary times, are doing everything possible to give us, at low cost, *priceless* life and health".

"If your hospital were a hotel", demonstrates that just as the treatments and services offered in a hospital differ from those in a hotel, so do costs. "This is no job for an amateur" shows that in hospitals as in industry nothing is left to chance or amateurs. As the modern hospital is vastly different and more scientific than the hospital of a quarter of a century ago, so the cost of hospital care is higher. In "I'll help you get well", a maintenance man is pictured telling the public that he and many other "unknowns" are all part of the hospital team and that, on an average, there are three employees on hospital payrolls for every two patients. He also points out that, in providing round-the-clock patient service, at today's higher wages, hospitals are under greater expense than ever before.

As well as the advertisements, the Association prepared press releases and background material of a general nature on the "why" of hospital costs. Administrators were called upon to assist the local newspaper editor by giving him specific data on the community's hospital in addition to the general material.

Public Speakers

To round out the newspaper and radio campaigns and to give them impact and continuity, the Association suggested that qualified speakers from the hospital board or staff be chosen to talk to local service clubs or on the radio.

In organizing the "Let's tell them why" campaign, the O.H.A. assigned certain periods for the various types of publicity. Radio was to be stressed from August 15 to Sepember 30; newspaper advertising throughout September; and press relations in September and October.

Press and radio coverage were excellent throughout the province. Many newspapers ran the sponsored advertisements including Kirkland Lake toward the north of Ontario, and Niagara Falls and Simcoe to the south. Several papers also used editorial material. Radio transcriptions were broadcast from many and various points, including Kenora, Timmins and Sudbury to the west and north.

Thus, thanks to the efforts of hospitals and the interest displayed by newspapers, radio stations, and service clubs, the Association can report that the results of the public relations campaign have been most encouraging.

H.I.—U.I.

H. I. and U. I. received scant mention in the recent speech from the throne. However, that does not mean that U and I shouldn't stay on our feet to see that no one steps on our toes. Puzzled? See our October issue, page 28.

for Safety . . . **FOR SERVICE**

buy *Ohio* medical gases



LEADER

For over a half century Ohio Chemical has pioneered in providing the purest of medical gases. Ohio developed the improved purification processes that brought several of our modern anesthetics to present standards. It was first to deliver completely reconditioned cylinders, cleaned, inspected, and sealed against tampering and dust.

SAFETY

Now Ohio cylinders offer never-before-possible operating ease and safety. Extensive research and testing have led Ohio to introduce specially formulated Nylon valve seats, tough, self-sealing Teflon valve packing, and Fluorolube lubrication for added safety and smooth, trouble-free performance.

SERVICE

Ever-increasing numbers of Ohio supply outlets in principal cities offer unmatchable delivery service of medical gases in all eight standard size cylinders. The same trained Ohio representative who can supply you with medical gases also calls frequently to check and service your Ohio-made anesthesia, resuscitative, and oxygen therapy apparatus, as well as sterilizers, lights, operating tables, and other equipment and supplies. Ohio meets your medical and surgical needs completely.

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OHIO HOSPITAL EQUIPMENT — Heidbrink Anesthesia Apparatus • Ohio Oxygen Therapy Apparatus • Kreiselman Resuscitators • Scanlan-Morris Sterilizers • Ohio Scanlan Surgical Tables • Operay Surgical Lights • Scanlan Surgical Sutures and Surgical Needles • Sterilbrite Furniture • Recessed Cabinets

OHIO MEDICAL GASES — Oxygen • Nitrous Oxide • Cyclopropane • Carbon Dioxide • Ethylene • Helium and mixtures • Also Laboratory Gases and Ethyl Chloride.

Notes on Federal Grants

Cancer

The Queen Elizabeth Hospital of Montreal, formerly known as the Homoeopathic Hospital, has just been allotted federal funds to assist its cancer control program. A cancer registry has been operated at the hospital since 1943 and the grant, which is shared equally by the federal and provincial governments, totals $11,650. Two senior radiologists, one specializing in radiodiagnosis and the other in radiotherapy, are staff members. This is the ninth institution in Montreal which has been assisted in some phase of cancer control work since the federal grants became available three years ago.

Construction

Newfoundland's newest cottage hospital, now nearing completion at Channel, will receive $31,240 from the federal government to help meet the cost of construction. The new 27-bed hospital, to be operated by the provincial health department, will provide medical and surgical services for about 7,000 people in the surrounding district and its out-patient department will be the centre for public health services in that area.

A grant of $78,000 has been allotted by the federal government to assist with the building of the Eastlawn Pavilion of the Ottawa Civic Hospital. The new pavilion replaces the now-obsolete Strathcona Hospital and will be used for the treatment of communicable diseases. When not required for this purpose, it will be used for minor surgical cases.

The federal government has just set aside approximately $125,000 to help meet the building costs of new hospitals in Weyburn, Kinistino, and Rosthern, and health centres at Buffalo Narrows, Sandy Bar, and Stoney Rapids, all in Saskatchewan. The largest grant of $75,000 has been allocated to the new Weyburn Union Hospital. When completed next January, it will have space for 70 beds; a 24-bassinet nursery; medical, surgical, and obstetrical facilities; a clinical laboratory; and an out-patient department which will serve as a health centre for the Weyburn health region.

A federal grant of $15,000, which will be matched by the province, has been awarded to the new hospital at Kinistino. Scheduled for completion this month, the new hospital will have space for 15 beds; a three-bassinet nursery; x-ray, surgical, and laboratory facilities; and a health centre for that area. The new hospital will replace a smaller one which has become obsolete.

More than $29,700 has been earmarked for the new Rosthern Union Hospital, which also replaces an older building. It is expected that the building will be completed next February and will contain 20 beds; a 14-bassinet nursery, a public health clinic, and medical, surgical, obstetrical, and x-ray services.

The health centres at Sandy Bay, Stoney Rapids, and Buffalo Narrows were all completed some time ago but, owing to changes in the regulations covering grants for building health centres, they have become eligible for grants totalling more than $4,100. The three health centres, operated by the provincial Department of Health, provide medical and health services in unorganized areas in the northern part of the province.

The University of British Columbia, Vancouver, has been allotted $26,000 from federal grants to help meet the cost of its new Student University Hospital. Located on the fourth floor of the Westbrook Building, the new hospital is to serve student and staff members, which would total approximately 7,000 people. It has space for 26 beds, an operating room, and x-ray facilities.

Professional Training

Four public health bursaries have been awarded to residents of Newfoundland. A doctor from Port aux Basques will spend three months taking a post-graduate course in obstetrics, gynæcology, and pædiatrics, at the St. John's General Hospital, St. John's, Nfld. and, later, will develop a program of improved child and maternal hygiene in his area. A man from St. John's has been awarded a bursary to take a year's course in psychology at the University of Toronto. On his return he will assist in developing mental health services in the province. The remaining awards go to two nurses, one from Corner Brook and the other from St. Mary's, who are to enroll for a six months' course in midwifery at the Frontier Graduate School in Midwifery in Kentucky, U.S.A.

In Prince Edward Island, four bursaries have been awarded. Three residents of Charlottetown will receive bursaries: a doctor will take a year's training in the various aspects of tuberculosis control at the Royal Edward Laurentian sanatorium in Montreal and Ste. Agathe des Monts, P.Q., and will join the staff of the Prince Edward Island Sanatorium on his return; a nurse will receive a two-year course in administration and supervision of public health nursing at McGill University, Montreal; and the third award will go to a woman to take a year's training in mental health at the University of Toronto. She will act as liaison between the schools and local mental health services on her return.

A doctor from Grand Falls, New Brunswick, has been granted a bursary to take a year's post-graduate training in public health at the University of Toronto. It is expected that he will join the provincial health department on completion of his training. A bursary has also been awarded to a woman from Edmundston, N.B., to aid in developing a dental health program in the province. She will take a year's course in dental hygiene at Columbia University, New York.

ENZYME-VITAMIN TEAM

aids digestion... supplements nutrition

TAKA-COMBEX is especially useful when caloric needs and vitamin requirements are highest—in illness and convalescence, pregnancy and lactation, in the very young and the very old.

It provides physicians with a combined digestive aid and nutritional supplement in convenient Liquid or Kapseal® form.

The vitamins assure patients adequate intake of important factors of the B-complex (C also, in the Kapseals). In addition, the B-vitamins are essential in carbohydrate metabolism.

The enzyme, Taka-Diastase,® is one of the most potent starch digestants known. It also enhances absorption of vitamin B.

TAKA-COMBEX® Liquid Kapseals

vitamin supplement and starch digestant

TAKA-COMBEX Kapseals

Each Kapseal contains:

Taka-Diastase (*Aspergillus oryzae* enzymes)	2½ gr.
Vitamin B_1 (Thiamine Hydrochloride)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	1 mg.
Pantothenic Acid (Sodium Salt)	5 mg.
Nicotinamide (Niacinamide)	10 mg.
Vitamin C (Ascorbic Acid)	30 mg.

With other components of the Vitamin B Complex derived from liver.

In bottles of 100 and 500.

TAKA-COMBEX Liquid

Each teaspoonful (4 cc.) contains:

Taka-Diastase (*Aspergillus oryzae* enzymes)	2½ gr.
Vitamin B_1 (Thiamine Hydrochloride)	2 mg.
Vitamin B_2 (Riboflavin)	1 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Pantothenic Acid (Sodium Salt)	2 mg.
Nicotinamide (Niacinamide)	5 mg.

In 16-ounce bottles.

MEDICAMENTA VERA · PD & CO.

PARKE, DAVIS & COMPANY

◂ Notes About People ▸

Superintendent Assumes Duties at Collingwood, Ontario

Amy White, Reg. N., a graduate of the Toronto General Hospital's School of Nursing, has assumed her new duties as superintendent of the General and Marine Hospital, Collingwood, Ont. Following graduation, Miss White was on the staff of the Toronto General Hospital and spent several years in private duty nursing. During World War II, she was a nursing sister with the Royal Canadian Navy and was stationed at H.M.C.S. Niobe, in Greenock, Scotland. Prior to assuming her new position, Miss White was night supervisor at the Hamilton General Hospital, Hamilton, Ont.

* * * *

Dr. J. M. Hershey Accepts Post in New York State Health Department

Dr. J. M. Hershey, of Regina, Sask., has resigned his position as assistant deputy minister of Public Health and director of Regional Health Services for Saskatchewan to accept a new post in New York State. Dr. Hershey has been appointed hospital medical consultant in the office of medical defence of the New York State health department, Albany, N.Y. Prior to his position with the Saskatchewan public health department, Dr. Hershey was Commissioner of the British Columbia Hospital Insurance Service.

* * * *

New Assistant Administrator at Chatham Public General Hospital

Richard Pearce has been appointed assistant administrator of the Chatham Public General Hospital, Chatham, Ont. and has assumed his new duties. A native of Unity, Sask., Mr. Pearce obtained his Bachelor of Science degree from the University of Saskatchewan and, during World War II, he served with the Royal Canadian Air Force. In 1949, he enrolled in the post-graduate course in hospital administration at the University of Toronto and received his diploma in hospital administration on completion of his administrative residency at the Victoria Hospital, London, Ont., this summer.

* * * *

James A. McNab Appointed to Post at New Hospital, Kemano, B.C.

James A. McNab, senior administrative resident at the Vancouver General Hospital, has been appointed hospital administrator at Kemano, B.C. The hospital, which opened recently, serves the employees of the Morrison-Knudson Co. of Canada Ltd. who are engaged in the present power development project.

Mr. McNab received his Bachelor of Commerce degree from the University of British Columbia in 1949 and, in the fall of that year, he enrolled in the post-graduate course in hospital administration at the University of Toronto. After completing his administrative residency at the Vancouver General Hospital, he was appointed senior administrative resident at the hospital in July of this year.



James A. McNab

Former Canadian Administrator Appointed to New Position

Clarence C. Gibson, F.A.C.H.A., formerly administrator of the Ector County Memorial Hospital, Odessa, Texas, has been appointed superintendent of the Norfolk General Hospital, Norfolk, Virginia, and has assumed his new duties. For many years, Mr. Gibson was active in the Canadian hospital field, where he served as administrator of the Regina General Hospital and, later, was in the service of the Saskatchewan department of public health. In 1947, he left the department to become administrator of the El Paso City County Hospital, El Paso, Texas.

* * * *

Chief Male Supervisor Retires from Nova Scotia Hospital

A. W. Leslie, chief male supervisor at the Nova Scotia Hospital, Woodside, N.S., has retired from active duty after 43 years of service on the hospital staff. Mr. Leslie was the second male nurse to graduate from the hospital and, for 31 years, he headed the nursing staff of the institution. He plans to make his home in Wilmot, N.S., and hopes to continue being of service to the field through the provincial department of health.

* * * *

New Matron at Saltcoats, Sask.

Anne Prokapition, Reg.N., of Yorkton, Sask., has accepted the position as matron of the Saltcoats and District Memorial Hospital, Saltcoats, Sask. Miss Prokapition fills the vacancy left by the resignation of Miss Doreen MacDonald.

* * * *

Personal Advisor Appointed

The appointment of S. D. Denman, of Montreal, as personal advisor to the minister of National Health and Welfare on civil defence planning and organization was announced recently. Mr. Denman will also act as special assistant to Maj.-Gen. F. F. Worthington, federal civil defence co-ordinator.



SEAMLESS "KOLOR-SIZED*" GLOVES

TRADEMARK

ARE STARTING A NEW LANGUAGE

● "I want to be *sure*, so I ask for Size Blue," reports one doctor. Numerical size stamping often grows illegible after several autoclavings. But colors can always be recognized. That is why more and more doctors are asking for a *color* instead of a *size!*

Thousands of hospitals are responding to this preference, and in doing so, are experiencing new economy and convenience. New economy, because nurses can sort Seamless "Kolor-sized" gloves faster, thereby saving time, money. New convenience, because "Kolor-sized" gloves avoid errors, embarrassment, and operating room delay.

Order Seamless "Kolor-sized" Brown Milled or White Latex Surgeons Gloves through your Hospital Supply Dealer. Order now for earliest possible delivery.

Write for FREE Sterilization Chart

Combination Sterilization Procedure and Color Code Chart. Ideal for posting where gloves are sterilized and sorted." Front shows color code for "Kolor-sized" gloves. Reverse gives approved procedure for sterilizing surgeons gloves, including —Preparation for sterilization...Sterilization by steam...Sterilization by boiling. Get extra life from your surgeons gloves. Encourage your staff in proper procedure. **Write for free charts today.** Please limit request to three.

FINEST QUALITY SINCE 1877

*Pat. Pend.

SURGICAL RUBBER DIVISION

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SEAMLESS

◂ Health Care Plans ▸

Canadian Blue Cross Plans Meet at Charlottetown

The Maritime Hospital Service Association (Maritime Blue Cross Plan) was host to the members of the Canadian Council of Blue Cross Plans at a special meeting October 5th, 6th and 7th. The scene of the meeting was Hotel Charlottetown, Charlottetown, Prince Edward Island.

During the meeting general agreement was reached on the development of a national uniform Blue Cross contract under which employees of a company located in more than one province would enjoy uniform protection at uniform rates. The contract is to be approved by the Governing Boards of each Canadian plan and, of course, is subject to the laws of each province affected. Other subjects discussed with a view to uniformity of operation include the Inter-Plan Service Benefit Bank, Inter-Plan transfers, enrolment and administrative procedures.

Canadian Council of Blue Cross officers appointed for two-year terms commencing next April were as follows:

Governing Board

President: J. R. H. Robertson (Montreal)
Vice-President: Dr. J. A. McMillan (Charlottetown)
Administrative Officers:
Chairman: Ruth Cook Wilson (Moncton)
Vice-Chairman: A. L. Crossin (Winnipeg)
Honorary Secretary: J. A. Monaghan (Edmonton)
Honorary Treasurer: E. D. Millican (Montreal)

The Canadian Plans form District XII of the Blue Cross Commission's territorial breakdown—Districts I to XI are in the United States. Mr. D. W. Ogilvie, Toronto, was appointed Commissioner, District XII, succeeding E. D. Millican, Montreal.

Mr. A. J. Swanson, current President of the Governing Board will retire from this position at the annual meeting of the Blue Cross Commission in April, 1952. He will continue as a member of the board. Other members of the Governing Board are Dr. D. R. Easton, Edmonton, and Dr. Owen C. Trainor, Winnipeg.

The Canadian Council is made up of five Canadian plans serving eight of the ten provinces. The five plans afford protection to 2,800,000 Canadians or roughly 25 per cent of the population in the area served.



At the Charlottetown meeting of the Canadian Council of Blue Cross Plans, these four were caught by the camera at Saturday night dinner. They are left to right: Rt. Rev. James Boyle; Hon. Alexander Matheson; Mr. A. J. Swanson; and Dr. J. A. McMillan.

Increase in Health Protection

All forms of voluntary health protection scored tremendous gains in 1950 to set new records, the Health Insurance Council reported recently in the fourth annual edition of its Survey of Accident and Health Coverage in the United States. The Council's report indicates that at least half of the nation's population at the end of last year was covered by one type or other of voluntary protection against the economic hazards of sickness and accident.

Hospital expense protection, which covers the largest number of people, was extended to 76,961,000 persons at the close of 1950. This total is 17 percent greater than the figure of 66,044,000 just a year before. Both surgical and medical coverages also have shown large postwar gains, with the 1950 number of persons in each case being more than quadruple the 1945 totals.

Protection against loss of income due to disability also increased during 1950. The 1950 total is equivalent to approximately 60 percent of the employed civilian population entitled to such benefits at the year-end.

The figures given in the survey cover various types of insurance companies, such as Blue Cross, Blue Shield, fraternal bodies, local medical societies, industries, and universities.

"Healer of Men"

Osler's writings along with those of Hippocrates and others great in the history of medicine will help to stir in the young student the ideals and the ambition to be a "healer of men"—not just a robot of science.—*"The Journal of Southern Medicine and Surgery".*



Picture the patient

... *before and after*

Today it's common practice with many physicians and surgeons to document each significant case with photographs made before and after treatment.

Common practice, too, is to use a Kodaslide Table Viewer, Model A, when presenting such pictures—particularly to small groups. This convenient projection outfit (illustrated) includes screen, projector, and changer in one unit. It takes standard 35mm. or Bantam slides, produces a brilliant image up to 5¼x7¼ inches in a fully lighted room. Weighs only 11 pounds complete with sturdy case.

Also available: Kodaslide Table Viewer, 4X. It provides sharp, radiant images enlarged over four times. Ideal for arranging and editing.

For further details—see your nearest dealer or write:

CANADIAN KODAK CO., LIMITED
Toronto 9, Ontario

Kodak products for the medical profession include:

X-ray films, screens, and chemicals; electrocardiographic papers and film; cameras and projectors—still- and motion-picture; enlargers and printers; photographic film—full-color and black-and-white (including infrared); photographic papers; photographic processing chemicals; microfilming equipment and microfilm.

Serving medical progress through Photography and Radiography

Kodak
TRADE-MARK

A true picture of hospital life

"White Corridors"

A TRULY realistic motion picture of hospital life is being released currently in Canada. Based, largely, on the best-selling novel *Yeoman's Hospital* by Helen Ashton, "White Corridors", a J. Arthur Rank production, stars Googie Withers, Sir Godfrey Tearle, James Donald, and other well known British character actors. The heart-moving film takes its audience into a small English country hospital and there, over a period of several days, unfolds the secret joys, sorrows, ambitions, hopes, and fears, of both the staff and patients.

The main plot, which is well integrated with the many and varied sub-plots, concerns the love of a young lady-surgeon and the hospital's research pathologist. Here, conflict of ambitions and desires build to a highly tense climax. Scenes depicting a probationer's first days on the wards, the connection of the hospital with the community through the hospital board, difficulties encountered by members of the national health service, a young doctor's negligence, and the fight to save a child's life, are but a few of the many incidents which add to the authenticity of the film. The errors and failures of the staff are presented, as well as their sacrifices and devotion to duty. The drama of the final scene is heightened by its simplicity and leaves the audience with a true impression of the never-ending work in a hospital.

Through much research and careful observation the scriptwriter, Jan Read, has recorded as much factual detail as possible. Indeed, accuracy of subject matter, expert direction, competent acting, excellent photography, and a heart-warming story combine to make "White Corridors" an extremely interesting and noteworthy film.



Humour . . . a bed available at last.



Tension . . . a life to save.



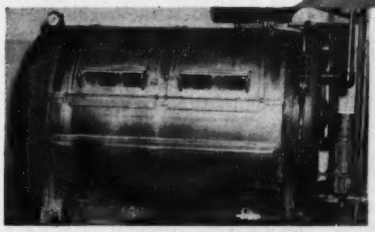
Drama . . . an experiment to prove.

THE 100-BED YORK COUNTY HOSPITAL

at Newmarket, Ont.

Another CANADIAN HOFFMAN Laundry Installation

Gets "high quality linens for our patients at a minimum cost."



Complete Laundry Equipment Service for Smallest to Largest Institutions

Write for Details Learn How You Can Save Floor Space, Time, Labour, Fuel Supplies and Linen

This modern-design Hoffman Washer processes loads with maximum economy.



Fast, high-quality flatwork is produced on this Hoffman 2-roll Chest-type Flatwork Ironer.



Built for heavy-duty, this Hoffman open-top Extractor provides thorough extraction, economy of power, convenient control.

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Provincial Notes

Newfoundland

CHANNEL. The new 27-bed cottage hospital, to be operated by the provincial health department, is now nearing completion. It will provide medical and surgical facilities for about 7,000 people and the out-patient department will be the centre for public health services in the district. A grant of $31,240 has been allotted from the federal government to help meet the cost of construction.

Nova Scotia

HALIFAX. An expansion program has been undertaken by the Children's Hospital. Proposed plans call for the construction of two new wings to the hospital and the addition of two floors to the present nurses' residence.

* * * *

HALIFAX. A new nurses' residence is being constructed for the Victoria General Hospital. It will contain 524 beds to accommodate nurses, x-ray and laboratory technicians, and other staff members. The residence will be connected with the main hospital by means of a tunnel and will have a recreation hall in the basement.

* * * *

SYDNEY MINES. Work is progressing on the new addition to the Harbor View Hospital. The three-storey wing will double the hospital's bed capacity to 100. Kitchen and dining room facilities will be located in the basement, the maternity ward on the second floor, and major and minor operating rooms on the third floor. Extensive renovations will be made to the present building when the new addition is completed. The projects are expected to cost more than $400,000.

New Brunswick

PACQUETVILLE. The Red Cross Society has recently opened a new nursing station here. This is the second outpost unit to be established by the Society in Gloucester County; the other station is located on Miscou Island, off the north-east tip of the province. A registered nurse will give home care to the ill or injured within a radius of 20 miles, as well as administering treatment at the station.

Quebec

GASPE. In September, the new 400-bed St. Camille Sanatorium was officially opened. Included among the features of the five-storey institution are sun galleries which extend for 1,300 feet along one side of the building and command a beautiful view of Gaspé Bay. Funds for the construction of the sanatorium were allotted by the provincial and federal government.

* * * *

HUNTINGTON. A joint campaign to raise $40,000 for the Barrie Memorial Hospital and the Huntington County Hospital is under way. Funds raised through the campaign will be used to increase facilities at the Huntington County Hospital and to help decrease the capital debt of the Barrie Memorial Hospital.

Ontario

ATIKOKAN. The administration of the 15-bed Red Cross Hospital will be turned over to the community as of December 31, 1951. Built in 1950, the Red Cross Society has operated the hospital since that time.

* * * *

BARRIE. An $85,000 campaign was launched recently to furnish and equip the new unit of the Barrie and District Memorial Hospital and to build a two-storey nurses' residence. Approximately $50,000 is needed for furnishnig and equipping the new unit and the remaining $35,000 will be used to help cover the cost of building the nurses' residence.

* * * *

CORNWALL. Construction is scheduled to begin this fall on a new $2,500,000, 250-bed Hotel Dieu Hospital. The building, which is expected to be completed in 1953, will replace the present Hotel Dieu Hospital.

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DUNNVILLE. The new Haldimand War Memorial Hospital was officially opened at the beginning of this month. Built to replace the former Dunnville Hospital, the hospital has a bed capacity of 40 and contains 18 cubicles.

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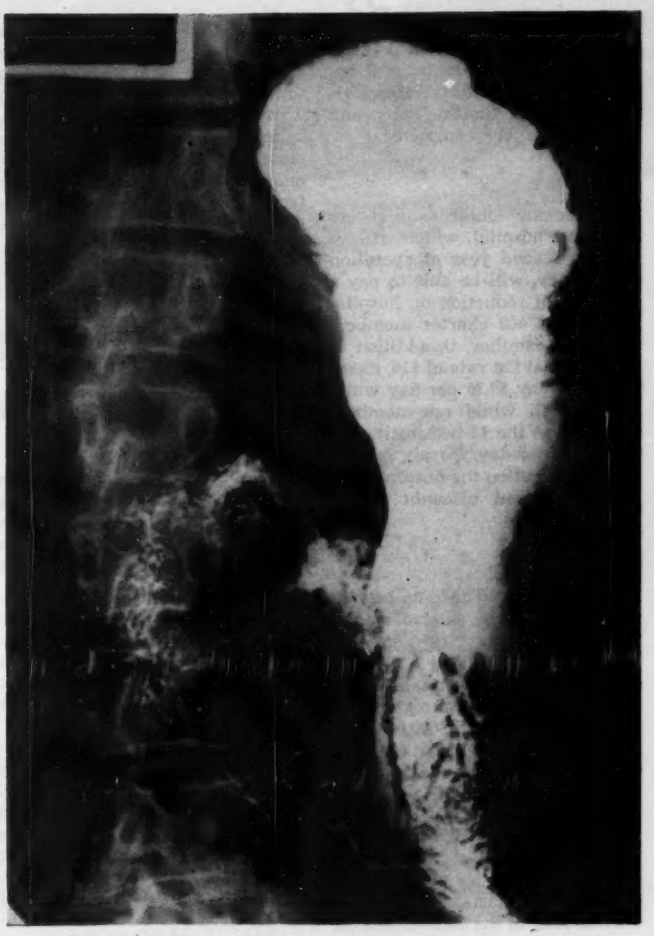
HAMILTON. A new emergency wing, which is being planned for the General Hospital, will be a one-storey building 40 feet wide and 120 feet long. It will be erected on a plot of ground between the out-patient department and the Queen Alexandria wing. Preliminary plans call for the new wing to connect through to the basement floor of the main building by way of the physiotherapy department. The estimated cost of the addition is $150,000.

* * * *

NORTH BAY. The Hon. MacKinnon Phillips, provincial health minister, has announced that a 1,200-bed mental hospital to serve northern Ontario will be built at

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North Bay. Although final plans have not been completed it is expected that construction will begin when the Ontario Hospitals at Brockville, Smiths Falls, and Port Arthur are completed.

* * * *

SHELBURNE. Ontario's first co-operative hospital, which will go into its second year of operation in January, will be able to pay a 50 per cent reduction on hospital care to its 400 charter members and their families. In addition to their annual flat rate of $10, members will pay $2.75 per day while in hospital, while non-members admitted to the 14-bed institution pay $5.50 per day. During its first year of operation the hospital paid a 20 per cent discount to its members.

* * * *

ST. THOMAS. The city council has approved the sale of debentures to meet the city's share of the cost of building the St. Thomas-Elgin General Hospital. A total of $660,000 in debentures will be issued this year and $600,000 next year. The council also accepted the recommendations that the present Memorial Hospital Nurses' Home be turned over to the St. Thomas-Elgin General Hospital Board at a nominal rental of one dollar per year and that the Memorial Hospital be turned over to the same Board for operation as a chronic unit.

Manitoba

WINNIPEG. The Victoria Hospital is currently appealing for funds to help cover the cost of renovations to the older section of the hospital and for equipment which was purchased for new rooms in the recent addition. Approximately $125,000 is needed to pay for the remaining expenses of the $450,000 project.

* * * *

WINNIPEG. From the annual report for the three Winnipeg municipal hospitals, it has been announced that operating expenses during 1950 cost the taxpayers $390,338. For the same year, a total of 61,844 days of treatment were given in the hospitals despite the Red River floods, which closed them for several weeks. A marked decline in the death rate from tuberculosis was also noted; in 1949 the death rate was 11.4 per cent of all patients in the hospitals and this number dropped to 4.8 per cent in 1950. The death rate from other diseases also dropped from .42 per cent in 1949 to .16 per cent of all patients in 1950.

Saskatchewan

LLOYDMINSTER. Many official guests attended the opening of the new Lloydminster hospital in September. The 43-bed hospital is valued at $360,000.

* * * *

NIPAWIN. Plans are being drawn up for the proposed construction of a 25-bed addition to the present 50-bed Nipawin Union Hospital. The two-storey wing, with basement, would be built so that more beds could be added in the future. The hospital board has received permission to put a proposed sale of debentures before the voters at the municipal elections this fall. Building costs are estimated at $165,000.

Alberta

EDMONTON. The Royal Alexandra Hospital has announced that its rates will be increased at the beginning of the year. Public ward accommodation will be increased from $5.50 to $7.00; semi-private ward rates will increase from $7.50 to $9.00; and private room rates will increase from $9.00 to $11.00. A financial statement for the first 8 months of this year shows an operating deficit of $131,000.

* * * *

LETHBRIDGE. A new 83-bed wing has been opened at St. Michael's General Hospital. Built at a cost of more than $300,000, the three-storey addition of reinforced concrete and brick boosts the hospital's bed capacity to 203. A medical ward and a three-room central services station are located on the first floor, the surgical ward on the second floor, and the pediatric department on the third floor.

* * * *

WESTLOCK. Recently, the new $500,000 wing to the Immaculata Hospital was opened. The addition and renovations to the older building increase the bed capacity from 30 to 77. Located some 55 miles north-west of Edmonton, the hospital serves an extensive area in the surrounding district.

British Columbia

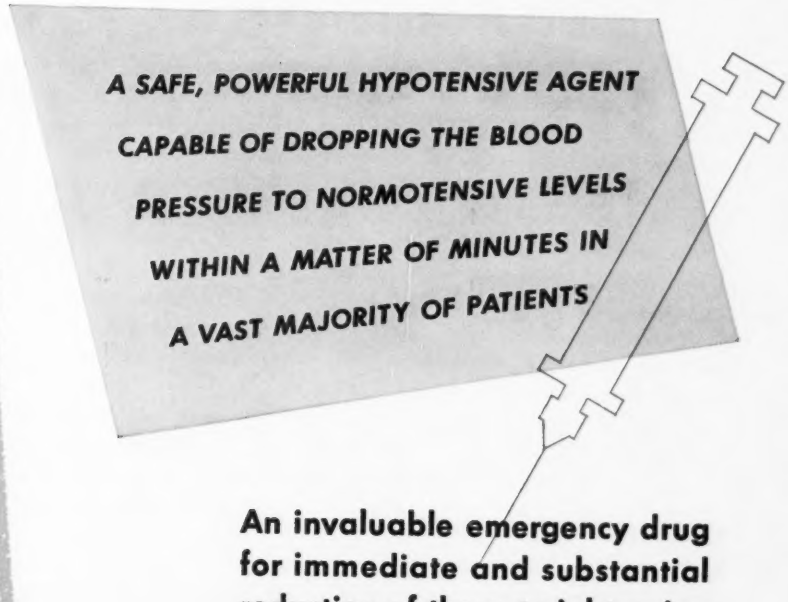
KEMANO. A 10-bed hospital to serve the employees of the power and smelter project, which is being undertaken in the northern section of British Columbia, has been completed. The hospital, which is under the medical direction of Dr. Leon Komar, formerly of Edmonton, has a staff of four nurses, a matron, and lay administrator. It has been equipped to handle many types of cases and has an operating room.

Quebec Hospitals Receive Raise in Indigent Patient Grants

The Quebec Provincial Government has approved a general increase in the amounts payable under the Quebec Public Charities Act for the care of indigent patients in hospitals, convalescent homes, and similar institutions throughout the province. The increases, which became effective on October 1st, are paid to institutions caring for sick persons receiving aid under the act and vary with the nature of the illness and the function of the institution. Hospitals classified AI under the Quebec Public Charities Act, which formerly received $4 per day for indigent patients, will now receive $5.50.

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With the Auxiliaries

B.C. Hospital Auxiliaries Hold Annual Convention

More than 45 voting delegates and 75 representatives registered for the annual convention of the British Columbia Association of Hospital Auxiliaries, which was held in Vancouver, on October 17 and 18. During the past year, eight new members have been added bringing the total membership of the provincial association to 95 auxiliaries, with over 5,000 members.

Summaries of annual reports were given and two of the attending auxiliaries were working for hospitals not yet built. The money earned by these auxiliaries was being accumulated to help furnish wings.

Delegates were entertained at a banquet on Wednesday night. At a luncheon on Thursday, Mrs. J. M. George, of Morden, Man., addressed the members on the work of women in the hospital auxiliaries field. Later in the afternoon, Judge J. M. George, president of the Associated Hospitals of Manitoba, spoke to the gathered representatives and stated that "fifty percent of the hospitals would have been closed if it had not been for the auxiliaries," and added, "when you lose voluntary effort, you lose the interest of the people". Judge George also offered $100 for a suggested contest to help auxiliary work.

Election of officers was held at the closing sessions on Thursday afternoon.

Officers

President: Mrs. H. C. McPhalen, Westview
First Vice-President: Mrs. Forbes Perkins, Vancouver
Second Vice-President: Mrs. F. E. Atkinson, Summerland
Third Vice-President: Mrs. Robert Mawhinney, Nanaimo
Fourth Vice-President: Mrs. George A. Bishop, Oliver
Secretary: Mrs. Arthur Woodward, Powell River
Treasurer: Mrs. C. S. Stigings, Vancouver
Publicity: Mrs. Ruby Sutherland, Vancouver.

Auxiliary at Leamington, Ont., Holds Annual Tag Day

Proceeds from the annual tag day, held by the ladies auxiliary to the Leamington District Memorial Hospital, Leamington, Ont., were $955.51. It was decided that material would be purchased and used to protect the seats and backs of the upholstered chairs in the patients' rooms. Members were busy this fall canning twelve bushels of peaches which were donated to the hospital.

* * * *

Auxiliary's Report Shows Notable Record of Achievements

The progress of the ladies aid to the Portage la Prairie General Hospital, Portage la Prairie, Man., since its inception in 1902 was traced at the first fall meeting. During that time approximately $46,910.69 has been raised. Last year a total of $3,363.30 was raised by the auxiliary. The most outstanding money-raising venture was the May Day collection. Throughout the year, members sponsored the nurses' graduation and dance, a cooking school, and tag day.

Three semi-private rooms of four beds each were furnished at an approximate cost of $3,458.79 and a wheel stretcher with rubber sponge cushion, which was valued at $170, was purchased for the hospital. Produce for the hospital was donated at the Hospital Harvest. Recently, the old operating room was redecorated and fitted out as a four-bed ward by the auxiliary.

* * * *

Hospital Receives $1,000 Cheque

A cheque for $1,000 was presented to St. Mary's of the Lake Hospital, Kingston, Ont., by the ladies auxiliary. This sum will be used to purchase equipment for the hospital. Members have decided to continue their support to the occupational therapy department in the amount of $25 a month and, also, to set aside $15 a month for patients' treats.

* * * *

"Miss Hospital Fair" Contest Feature of Kentville Hospital Fair

The senior ladies auxiliary to the Blanchard Fraser Memorial Hospital, Kentville, N.S., sponsored a "Miss Hospital Fair" contest at the Kentville Hospital Association's annual fair. A total of 10,740 ballots were cast for the various contestants, netting over $500 for the hospital. A trophy was presented to the winner of the contest and all other contestants received gold compacts from the auxiliary. The gross income from the fair was approximately $6,300.

* * * *

Auxiliary Assists at Opening of New Hospital Wing

Tea was served to visiting speakers and guests by the ladies auxiliary at the official opening of the new wing to the Vegreville General Hospital, Vegreville, Alta., in October. Members recently donated a cheque for $180 to pay for a projector for the nurses' training school.

* * * *

Auxiliary Aids Cancer Drive

A total of $469.55 was raised by the women's auxiliary to the Wadena Union Hospital, Wadena, Sask., for the Cancer Drive. On October 20th, the members held their annual hospital bazaar and tea. Funds for the auxiliary's work throughout the year are raised at this annual event.

Lowering Tuberculosis Death Rate

At the beginning of the century, Canada was among the group of nations with the highest tuberculosis death rates. Today, this country has one of the lowest rates in the world. On the basis of the most recent statistics, only two countries—Denmark and the United States—have lower rates than Canada. — *Canadian Tuberculosis Association "Bulletin"*

Revised Procedure for

Appointment of Interns

THE Canadian Intern Placement Service (C.I.P.S.) is an activity sponsored by the Canadian Association of Medical Students and Interns (CAMSI) with a view to providing Canadian students with the widest possible choice of internships; and approved and commended Canadian hospitals with the widest possible choice of interns. C.I.P.S. does not guarantee to any hospital that interns will be supplied, nor to any student that an internship will be available at any specific hospital. The number of internships exceeds the number of graduates, hence there are bound to be vacancies in the hospitals.

The function of C.I.P.S. is confined to final year students at participating Canadian Medical Schools, who are seeking their first rotating internship in approved and commended Canadian hospitals. Physicians, who are already graduated at the time of application or who are seeking training in special fields, should not be included in lists submitted by hospitals. Hospitals may make private arrangements with applicants who are not current Canadian graduates.

Procedure

1. Each final year medical student will apply for internship to the administrator or the intern committee of each of the hospitals in which he desires to intern. These applications must be in the hands of the hospitals as early as possible and not later than January 15th, 1952.

2. The medical student will enter on a Student Form (supplied by C.I.P.S.) the names of the hospitals to which he has applied for an internship, in the order of his preference, and send the form to the C.I.P.S. before January 15th, 1952. Each student form must be accompanied by the required fee of $1.00. (Cheques or money orders should be made payable to Secretary - Treasurer, Canadian Intern Placement Service, 135 St. Clair Ave. W., Toronto). It is recommended that students make application to a sufficient number of hospitals to ensure assignment to one of them.

3. The hospital administrator or Intern Committee will rank the applicants in the following two groups, from an investigation of the applications, personal interviews, hospital examinations, letters of recommendation, or any other data that may be available.

Form A—Those whom the hospital definitely desires as interns, listed in the order of preference.

Form B—Those whom the hospital will appoint should any applicants on Form A be eliminated, i.e., alternates or second choices, listed in order of preference.

The hospital will enter the names of the applicants in these two groups on Forms A and B respectively (to be supplied by the C.I.P.S.) and send the forms to the Canadian Intern Placement Service, on or before February 10th, 1952. It is strongly recommended that hospitals indicate their order of preference for *all* applications received. If a hospital does not list all applicants, it is neglecting a possibility of filling more vacancies.

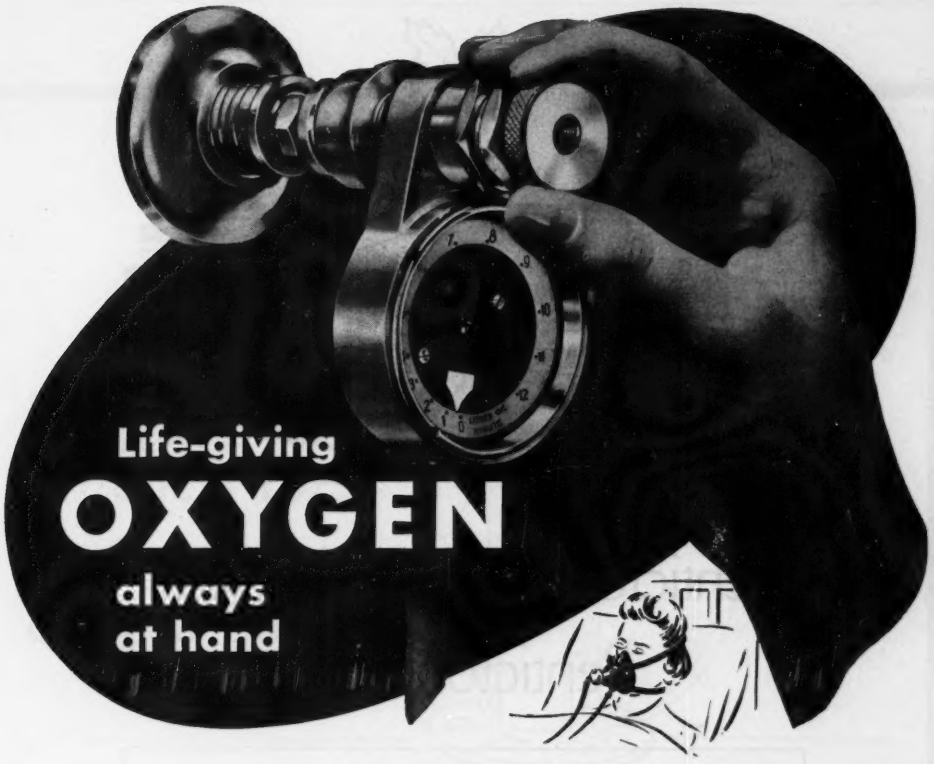
4. The C.I.P.S. will assemble the student forms and the hospital forms A and B and, by a process of dove-tailing, will assign to each hospital the students appearing on Form A. In cases where a student's name appears on more than one Hospital Form A, he will be assigned to the hospital appearing highest on his preference list (student form). His name will then be deleted from all other hospital forms A on which it appears, thus creating vacancies for alternates in these hospitals. The C.I.P.S. will then fill these vacancies from Form B, submitted by the hospitals, using the same method as followed above. By this means, hospitals will control the filling of gaps on their forms A. The C.I.P.S. will continue this process of dovetailing hospital and student forms until the lists of choice have been exhausted. This is a mechanical process only and C.I.P.S. has *no choice* in assigning students. C.I.P.S. cannot influence the students or the hospitals in their choices.

5. C.I.P.S. will serve only those students desiring to intern in Canadian approved or commended hospitals. Students desiring to intern in hospitals other than those on the Canadian Medical Association's Approved or Commended List will be required to make their own arrangements for such internship. If a student desires to apply to both Canadian and American hospitals, C.I.P.S. will handle his application only if the Canadian hospitals stand higher on his preference list than the American ones. Note: Canadian students applying to American hospitals should submit their applications prior to December 18th, 1951.

6. The C.I.P.S. will send to each hospital, by telegram, a list of all the medical students assigned to it by the above procedure on March 14th, 1952 and, on the same date, will advise each medical school of the assignment of its students. In the case of hospitals with unfilled quotas, a list of unplaced students, by university, will be included in the telegram.

Hospitals should immediately notify the students assigned that they in fact are offered an appointment. This notification should be carried out by wire in the case of students residing at a distance and, in any case, it should be dispatched on March 14th, 1952. In turn, students so assigned and receiving the notification should reply to the hospital by March 17th, 1952. C.I.P.S. will notify unplaced students as to the hospitals still requiring interns as soon as possible after February 19th, 1952. Negotiations will then be conducted independently of C.I.P.S.

(Concluded on page 108)



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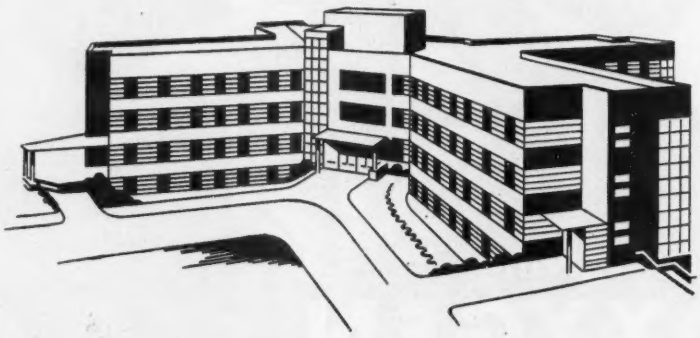
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(Continued from page 30)

ratus consisted of ordinary tea kettle set on a chair with a short length of hose carrying steam from the kettle to the child's crib. Child placed in a crib fitted with a sheet as a canopy and steam introduced under the canopy by the hose. In some unaccountable way and without any proven negligence on the part of the hospital or its employees, the child was found severely scalded. Held that since evidence was that the apparatus if operated with care was satisfactory, there must have been absence of proper care. Damages awarded to parents of the child by Ontario Supreme Court Judge. *(Harkies vs. Lord Dufferin Hospital, 1931 (2) D,L.R. 440)*

Case V

Plaintiff entered hospital with cataract on each eye, but for removal of cataract on right eye only. Cataract of right eye successfully removed and patient was progressing favourably. During a noon day meal while in the act of taking soup fed to her through a tube, something happened as to which the evidence was conflicting. Feeding patients was a routine matter with this nurse and she failed to concentrate. She denied that any soup spattered onto the plaintiff's face but remembered patting the plaintiff's face with a serviette. Overwhelming evidence that after the accident there were reddish patches on plaintiff's face below the mask. Upon re-examination surgeon found that a prolapse, or "protusion out" of plaintiff's eye had occurred. In final result plaintiff lost sight of eye. Evidence was that but for the prolapse plaintiff would have had good post-operative result in right eye. Judgment for $4,000 by Ontario High Court. *(Wyndham vs Toronto General Hospital, 1938. O.W.N. 55)*

Case VI

Infant plaintiff had been a diphtheria patient in defendant's hospital and had been discharged therefrom as cured and returned home. Found nine days later to be suffering from smallpox, the incubation period of which is ten to fourteen days. Damages were claimed from the defendant hospital upon the grounds that smallpox had been contracted owing to its negligence, the negligence charged being: the placing of smallpox patients next to the plaintiff and the attendance upon the patient by nurses who also attended the smallpox patients. Technique adopted by the hospital was known as the "sterilization method". The hospital was prepared to admit that smallpox had been contracted by virtue of what is termed "cross infection" while she was in a room on the third floor of the hospital and while she was attended by nurses assigned without discrimination to the patients on that floor. This technique had the approval of all the senior medical authorities in Vancouver and had been adopted after a deputation of both Vancouver City authorities and Vancouver General Hospital authorities toured the hospitals of the U.S. Held that a defendant charged with negligence can clear his feet if he shows that he has acted in accord with general and approved practice. Held by the Judicial Committee of the Privy Council that the only question to be decided was whether the plaintiff had succeeded in proving that the defendants were negligent in adopting the hospital technique in question and that in view of the favourable opinion expressed by all the defendant's medical witnesses regarding the said technique, the absence of any contrary opinion except that of the plaintiff's own physician, and due also to the fact that the said technique was in accordance with the general, if not universal, practice in Canada and the U.S., the charge of negligence failed. *(McDaniel vs. Vancouver General Hospital, 1934. (3) W.W.R. 619—Privy Council)*

Liability to Non-Patients

The following three cases illustrate the liability of hospitals to those other than patients. Such liability depends upon whether the person injured is

(a) An invitee, for example, doctors, nurses, delivery men

(b) A licensee—such as visitors to the hospital

(c) A trespasser—those with no business whatever in the hospital.

Case A

A lady visiting a patient of the defendant hospital, stepped on a mat, slipped on the highly polished linoleum on the floor, fell, and was seriously injured. The polishing was for a good cause, namely for antiseptic purposes. The court held that the hospital authorities, being aware of the polish and of the probable movement of an unanchored mat when stepped upon, were guilty of negligence to the visitor in failing to remove the mat or leaving it and failing to make it fast and were held liable to the plaintiff. *(Weigall vs Westminister Hospital, "The Solicitor", 1936, page 114)*

Case B

A pupil dietitian was injured in an accident caused by the fall of a dumb waiter used to carry food from the basement to the second floor. The dumb waiter was raised and lowered by a rope operated by the student nurse. The hoist fell, crushed her forearm. It is not clear whether the rope broke or became detached from the top of the car. No evidence of recent inspection of the rope. The pupil nurse denied that she had been instructed in the use of the side door which she failed to employ. The Superintendent's evidence was that she had instructed the plaintiff in the proper use of the hoist. Held that there was both negligence and contributory negligence, two-thirds by the defendant and one-third by the plaintiff. *(Jarvis vs Oshawa General, 1931 O.R. 482)*

Case C

In an action for injuries to a cripple, slipping and falling on a slick concrete walkway, sloping upwards towards entry to medical clinic building, to which he was going for eye examination, evidence of defendant's negligence in having a sloping walk, along which the defendant must have known that people with defective limbs would walk, was held sufficient to support the

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jury's verdict for the plaintiff. *(Span vs Norwood. U.S.A. case).*

As partial protection for claims alleging negligence on the part of the hospital, many institutions take from patients about to undergo an operation a general release. This practice has certain attractive features. One is that it acts as a deterrent to the bringing of ill-founded actions. An objection from the ethical point of view is that a public institution should be prepared to answer for its deeds, careful or negligent and should not seek to escape just punishment for its misdoings, if such there be. Another objection is that if such release is presented to the patient a few seconds before surgery is performed, the patient may later on be held not to be in such mental condition as to be answerable for his action.

Assault

You no doubt think of assault as the unjustified battering of one person by another. There are other forms. It has been held many times that the performance by a surgeon of an operation not authorized by the patient, constitutes assault.

Consent to operations: No surgical operation should be performed on an adult patient without his or her consent, if it is possible to obtain it. No operation in fact should be performed on a patient without the express consent of the patient in writing or, if he is not in a position to give such consent, of his nearest relative. The consent of the patient should be founded upon full knowledge of the nature and possible extent of the operation and the consequences which it may involve. Disregard of these rules will render the surgeon and hospital liable to an action for damages. In the case of a child, similar rules should be adopted except that, instead of the patient's consent, the consent of the parent or guardian should be obtained.

Varying operation from that to which consent was given: No operation must be performed by the surgeon other than the one for which consent has been given.

To illustrate: The plaintiff, a master mariner, brought action for $10,000 damages against the defendant, a surgeon of high standing in the City of Halifax, claiming that the surgeon while performing an operation on the plaintiff for hernia, while the plaintiff was under the influence of an anæsthetic, without the knowledge or consent of the plaintiff, removed an organ, the removal of which was not authorized. The plaintiff claimed that in removing the organ mentioned, the defendant committed an assault upon him. The defendant claimed that the removal of the additional organ was a necessary part of the operation for hernia and that the necessity for removing the organ could not have been reasonably ascertained by diagnosis before the operation and that consent to the further operation was implied by the plaintiff's request to cure the hernia. The defendant called as witnesses three eminent surgeons, all of whom agreed that if the additional organ had not been removed, the man's health and possibly his life, might have been in danger. Held that when during an operation a practitioner forms an opinion that it is necessary, in order to save the patient's life, to remove some organ or limb, and accordingly removes the organ or limb, the practitioner cannot be charged with negligence for having taken that step, unless there is evidence that express instructions were given by the plaintiff that no organ or limb should be so removed and that the operation was performed negligently. *(Marshall vs Curry, 60 C.C.C. 136)*

To illustrate further: (American case) A young lady stepped on a nail which penetrated the third toe of her right foot and inflammation set in. The wound not having healed, the surgeon made an examination and advised

(Continued on page 102)

C. S. R. T. Holds Annual Meeting

The Canadian Society of Radiological Technicians held a very successful convention in Winnipeg, Man., from September 12th to 15th. Technicians from all parts of Canada were in attendance and the business, educational, and social aspects of this annual meeting were of a very high order.

It was our privilege to have as honoured guests, Fred Melville, Executive Secretary of the British Society of Radiographers, Alfred B. Greene, Executive Secretary of the American Registry of X-ray Technicians, and Alec Turner, President of the American Society of X-ray Technicians. Dr. G. Gill, Secretary of the Canadian Association of Radiologists and Dr. Jean Bouchard, both of Montreal, were also present.

During the session, Fred Melville of the British society presented honorary memberships to Alec Turner of the American society and to William Doern of the C.S.R.T. In turn, Mr. Doern presented Honorary Life Memberships in the Canadian society to Mr. Melville and to Alfred B. Greene of the American Registry.

Among the many lecturers were Robert Mahoney of the General Electric X-Ray Corporation, Milwaukee, and Dr. A. E. Childe of Winnipeg.

A cocktail party sponsored by the Manitoba radiologists preceded the annual banquet and dance with which the convention concluded. A reciprocity agreement between the Canadian society and the American Registry of X-ray Technicians is now in force and it is hoped that a similar agreement will be reached between the Canadian society and the British society within a short time.

Officers Elected

Honorary President: Dr. Harcourt B. Church, President C.M.A., Aylmer, P.Q.

President: W. Q. Stirling, Vancouver, B.C.

Secretary-Treasurer: Donalda Campbell, R.T., Montreal, P.Q.

Registrar: Mrs. Mina Stewart, R.N., R.T., Winnipeg, Man.

Representatives to the Board of Directors: Dr. E. A. Petrie, Saint John, N.B., (appointed by the C.M.A.); Dr. G. Gill, Montreal, P.Q., (appointed by the C.A.R.)

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The check-list opposite . . . based on material included in the "Index" . . . presents a point-by-point comparison of the dramatic benefits of the two therapies.

And . . . of utmost importance to the administering physician . . . these findings prove conclusively that succinate-salicylate (AMBERMIDE) provides additional advantages:

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2. Increase of the urinary excretion of uric acid.	YES	YES
3. Inhibition of the action of hyaluronidase.	YES	YES
4. Decrease of circulating eosinophiles.	YES	YES
5. Reduced production of serum gamma globulin and antibodies.	YES	YES
6. Decrease in allergic response.	YES	YES
7. Clinical relief of rheumatic symptoms.	YES	YES
8. Increase in tissue oxidation.	YES	YES
9. Promotion of phosphorylation.	YES	YES

● **YOURS:** We shall be pleased to send you a copy of the AMBERMIDE "Index of Arthritic and Rheumatic Therapies—1951." Please write to Dept. 1, THE PAN PHARMACALS LIMITED, Toronto 10, Canada.

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*Salicylamide

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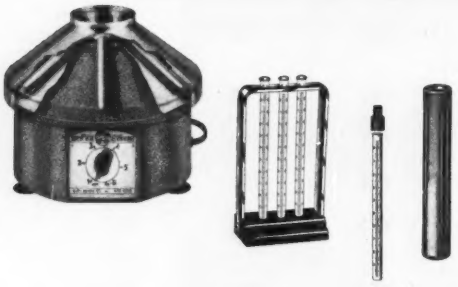
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In the original technic for determining the blood sedimentation correction factor for the V.P.R.C. (volume packed red cells), Dr. M. M. Wintrobe, of the University of Utah School of Medicine, specified 30 minutes centrifuging at a speed of 3000 R.P.M. Since the efficiency of centrifuging varies directly with the radius of the swing and as the square of the speed, the variation in the radii of the swing on different types of centrifuges is an important factor.

Tests run by Dr. G. E. Cartwright, Dr. Wintrobe's associate, have produced some interesting and valuable data – namely, that on the conventional, horizontal, free-swinging type of centrifuge, a relative centrifugal force (R.C.F.) of 2250 was required to produce maximum packing of the red cells in centrifuges.

Simultaneous series of tests run on the Adams Safety-Head Centrifuge (Model CT-1002) showed that a maximum packing of the red cells was attained with an R.C.F. of 1450 in 30 minutes. This proved that the Adams Safety-Head Centrifuge had approximately 35% greater efficiency than the conventional, horizontal, free-swinging centrifuge.

As a result of these tests, Dr. Cartwright states that this instrument is satisfactory for the doctor's office and adequate for determining V.P.R.C.

Since many clinical centrifuges now in use give a speed of 3000 R.P.M. without the required R.C.F., it is suggested that centrifuges used for this purpose be re-evaluated. Form No. 196R9, available from Clay-Adams, contains complete instructions for determining R.C.F.

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- Anatomical Charts & Atlases
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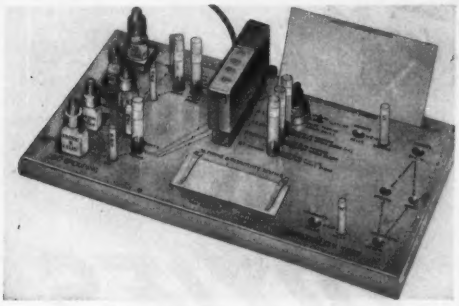
SPECIAL LITERATURE AVAILABLE

Detailed descriptions on the following may be obtained from Clay-Adams on request by number:

Brown Blood Board	Form No. 445R
Polyethylene Tubing and Accessories	Form No. 447B
Adams Centrifuges	Form No. 309R5
R.C.F. Calculations	Form No. 196R9

Newsletter

FOR THE MEDICAL AND BIOLOGICAL SCIENCES
Number 6 of a Series



Brown Blood Typing Board Cuts Down Human Error

Blood typing prior to transfusion places a grave and unique responsibility on the laboratory technician. Here is one laboratory routine where the physician is inclined to rely on the technician's findings. Usually, laboratory results are used as checks against case histories and physical findings.

Serological tests, however, stand alone. Negative results are as significant as positive; there are few inherent checks in the tests, and they are often performed under great pressure. This, plus the increasing complexity of crossmatching and agglutination tests in the past five years, has greatly increased the chances for human error. The technician who is entrusted with the laboratory tests related to blood transfusion must have a thorough training and understanding of the procedures.

The Brown Blood Grouping and Cross Matching Board was developed in the Blood Bank of Duke University to minimize these dangers. All routine procedures are indicated directly on the board. Each bottle and tube is of distinctive shape and fits into its own hole. All tubes and bottles bear permanent labels, with identifying colors, and the technician is compelled to complete typing and crossmatching of one sample before proceeding to the next.

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Tube Making—Gastric tubes are easily made by one of two ways. A suitable form, such as the tapered end of a centrifuge tube, is heated gently and the tubing slipped into it while it is rotated. The polyethylene takes on the shape of the tip of the test tube. In the second method, half of a gelatin capsule is slipped over the end of the tubing. This facilitates passage of the tubing, and once in the stomach the gelatin dissolves away from the open end of the tube.

For Coupling the tubing to a syringe, a variety of Luer-lock couplers is available. The tubing is sealed securely in place by using a heat flare without cutting down the lumen of the tube. Animal-tested polyethylene tubing is available from Clay-Adams in 23 different sizes, from 0.011 to 0.50 inches inside diameter.

Centrifuge Tube in a Stand Simplifies Urinalysis

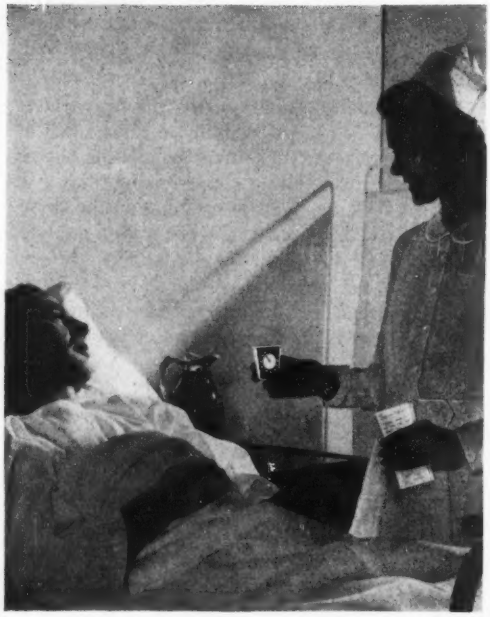


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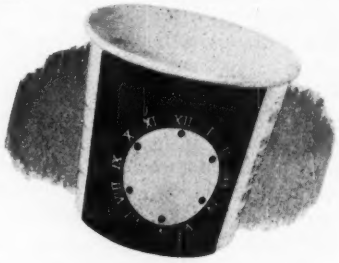
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Budget Time

(Continued from page 35)

current period, column 3 the expenditure per patient-day during the current period, column 4 the estimated total expenditure during the budget period, column 5 the estimated expenditure per patient-day during the budget period, and column 6 the reference letter under which the explanation will be found in the explanation portion of the budget.

Usually it falls on the accountant and the business office staff to prepare the hospital budget after consultation with the administrator. Where a hospital is departmentalized, it is desirable to departmentalize the budget and to require each department head to prepare the draft for his department. When the various departmental budgets are combined into a total budget for the hospital, usually by the business office, the budget is then reviewed by the administrator and also by the hospital board of management. Normally the budget should not be acted upon until the approval of the board of management has been obtained; and normally the administrator will not find it necessary to refer to the board of management any matters throughout the year which have already been approved in the hospital budget. Any financial matters that come up during the year that have been omitted from the hospital budget will normally be referred to the board of management for approval prior to the making of any commitments by the administrator.

As salaries form a large proportion of the total hospital operating cost, considerable time in the preparation of the salary portion of the budget is desirable and is warranted. Normally each position at the hospital is listed and the salary for the coming year is calculated, based on the rates of pay for the position, any changes that are contemplated from union agreements, holiday relief where necessary, and also relief for sickness where the employee is allowed sick leave with pay. Where employees are required to work overtime, and where such overtime is paid for, this factor must also be considered. Where employees are required to be paid for holidays if they do not take them, this factor must also be noted. The discontinuance of any position or the provision for new positions must receive the earnest consideration of the person drafting the budget and the close scrutiny of the administrator in reviewing the proposed change. If persons receive board and room at the hospital, normally the net amount of salary will go into the salary section of the hospital budget, as the cost of providing the living quarters and meals will show up in the remainder of the expenditure portion of the budget. An alternative method for handling the item of board and room is to show it as a revenue on the revenue budget or to show it as a deduction from expense in the expenditure portion and, in this case, the gross salary paid to each person is shown in the salary portion of the expenditure budget.

It has become fairly universally established that depreciation is one of the costs of running any hospital. For this reason, an allowance for depreciation on buildings, furniture, fixtures and equipment including trucks, automobiles, and ambulances, should be shown on the hospital budget. Depreciation is normally calculated by ascertaining the original cost of each depreciable item in the hospital and spreading this cost over the estimated useful lifetime of asset, an equal amount being charged to each year.

I do not propose to deal in detail with all the various expenditures which make up the total cost of operating a hospital, but I would like to spend some time on the more important expenses. The expense for food will normally be based on the current cost of each meal served at the hospital, multiplied by the number of meals the hospital expects to serve in the budget period. The normal estimate for medical and drug supplies will be based on patient days and any expected changes in the volume of service in the professional care departments. The estimates of repairs to buildings and furniture should be based on the projects which you expect to accomplish during

(Continued on page 98)

Catholic Hospitals of B.C. Hold Annual Meeting

The twelfth annual convention of the British Columbia Catholic Hospitals was held in St. Paul's Hospital, Vancouver, October 14-15. Guest speakers included Rev. Father Hector L. Bertrand, president of the Catholic Hospital Council of Canada, A. H. J. Swencisky, president of the British Columbia Hospitals' Association, and Percy Ward, secretary of the B.C. Hospitals' Association.

For the purpose of discussing moral and ethical problems, a special Chaplains' and Doctors' Session was held. Other highlights of the convention included an interesting skit on the care of premature infants who are brought in from outside points by specially equipped ambulances and aircrafts for admission to the premature unit in the paediatric department at St. Paul's Hospital; a lecture on the "Nursing Aspects of Atomic Warfare" by Mary Henderson, Reg.N., B.Sc., who is educational director of the Metropolitan Health Unit, Vancouver; and the reports of delegates to the Canadian Hospital Council Biennial Meeting, the Catholic Hospital Council meeting in Ottawa, and the American Catholic Hospital Convention in Philadelphia, Penn.

Officers

President: Sister Leo Francis, St. Mary's Hospital, New Westminster.

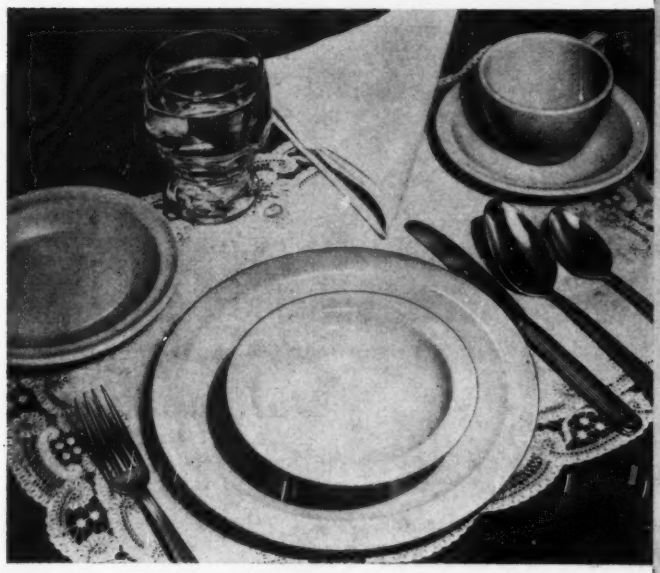
First Vice-President: Sister Mary James, St. Vincent's Hospital, Vancouver.

Second Vice-President: Sister Rose Mary, St. Joseph's Hospital, Victoria.

Secretary - Treasurer: Sister Laura Marie, St. Paul's Hospital, Vancouver.

Councillors: Sister Marguerite, St. Joseph's Hospital, Vancouver; Sister Alexina, St. Vincent's Hospital, Vancouver; Sister Lucita, St. Joseph's Hospital, Vancouver; Sister Marie Stella, St. Joseph's Hospital, Comox.

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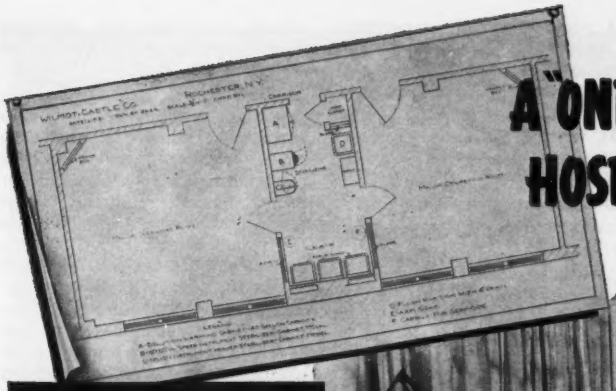
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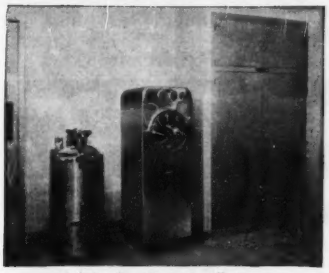


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*The Canadian Hospital, Vol. 28, No. 7, p. 79, July, 1951.

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Nursing Education

(Continued from page 31)

planning should promote a realization on the part of the community of its responsibility for nursing education and the place of nursing in community health.

Setting Up a Central School

May we now consider briefly the procedure which may be followed in setting up a central school. This has been very clearly set forth in Bulletin No. 4 published by the National League of Nursing Education and entitled *Nursing Education in Wartime*. The major steps to be taken in co-operative planning are as follows:

1. Form a committee.
2. Formulate purpose of co-operative program.
3. Make a survey of potential facilities.
4. Draw up final plan and budget.
5. Procure necessary approval from co-operating institutions.
6. Recommend or select personnel.
7. Recruit students.
8. Set plan in operation.
9. Evaluate success of plan.

A very interesting experiment at present being developed in Britain is the establishment of group schools of nursing. A letter to the *Nursing Times* of June 2, 1951, written by Miss J. E. Clark of Sheffield, gives the following vivid picture of the results, to date, of such group planning in nursing education in that country:

"I was interested to read the account of the Southampton Group School of Nursing published in your journal of May 5. Such schools are indeed an important trend in nursing education, and will no doubt become more widespread throughout the country when the Area Nurse Training Committees begin their work. Having had experience in working in a hospital which participates in such a scheme of student nurse training, I should like to say that a good deal of readjustment has had to take place between the old method of individual training schools and the new method of joining large and small schools together and grouping them centrally, apart from any of the hospitals.

"Each student on making application for training is allowed to choose in which hospital she wishes to take the greater part of her training. It then becomes her parent hospital and she is not permitted to change. She joins the group Preliminary Training School and later the Blocks held in the school, returning afterwards to work in her parent hospital. The question of a nurse's loyalty has presented quite a few problems and many wonder whether they belong to the Group School or to their parent hospital. Inter-hospital contacts help to encourage healthy competition and rivalry but can only be of use if each and every nurse feels that she can put down roots and know that her own individual effort is needed in the group.

"The main factor is that there must be complete co-operation between the matrons, tutors, and ward and departmental sisters. Personal differences must be

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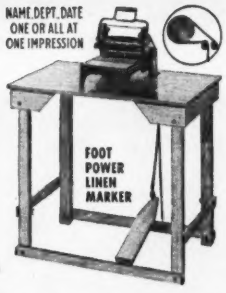
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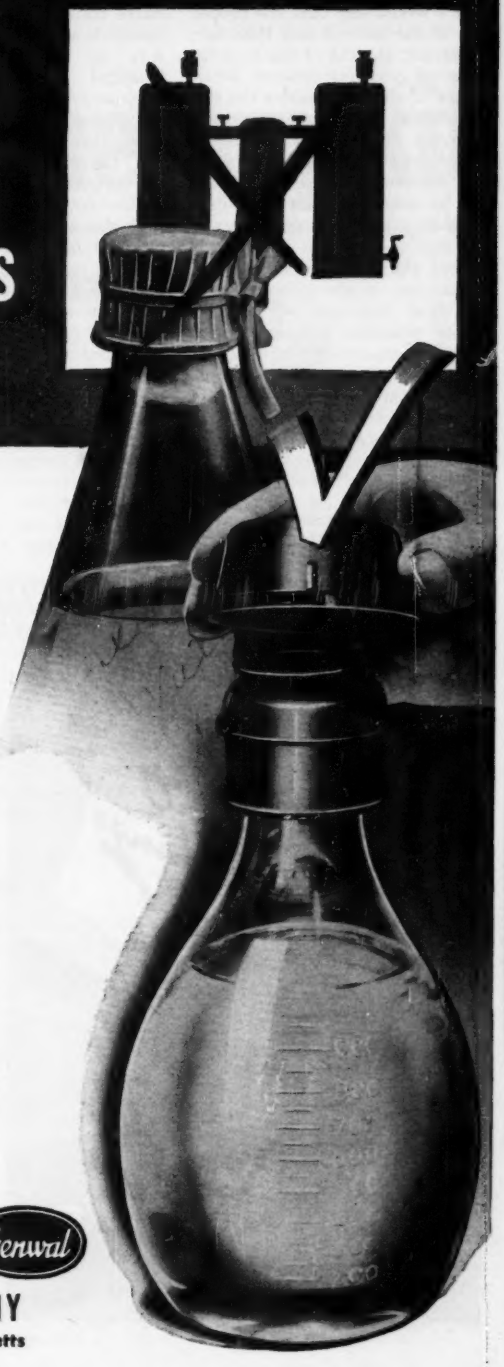
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overcome and the nurses' training a matter of prime importance. Here I would say that the proper care of the patient and therefore the proper staffing of the hospital is also of great importance. While we are unable to consider the student nurse as a supernumerary and have to count her as a member of the staff, these two important factors must be considered side by side. Matrons and tutors together are responsible for seeing that each nurse is properly trained and prepared for the examinations, while matrons have the dual responsibility of the nurses' practical training under adequate supervision in the hospital and of providing proper nursing care for the patients. Hence the need for appreciating each others problems and discussing them without prejudice.

"Ward sisters must know the methods of practical work taught in the classroom; sister tutors should be welcomed in the wards and know that what the nurses have learnt in the classroom will be carried out there. Meetings to discuss practical procedures or other problems connected with nurse training common to all the hospitals seem to be a satisfactory way of achieving uniformity. Hospital grouping and central schools are part of the plan for improving nursing education within the National Health Service. Let us therefore set out on this venture with high ideals and enthusiasm, laying aside personal prejudice and ambition."

In summing up, the general objectives underlying the establishment of central schools of nursing might be stated as follows:

1. To give the student a better than ordinary understanding of community needs and nursing care.

2. To produce nurses interested in small groups, small hospitals and rural community work.

3. To prepare nurses, conscious of the fact that hospital experience is but one part of the patient's experience during his illness.

4. To develop in the student the awareness that nursing care in hospital is only one part of health conservation and cure of disease.

5. To place a greater emphasis on basic scie.. es, both biological and social, than is possible in the ordinary hospital school.

6. To give a community emphasis for a non-urban region.

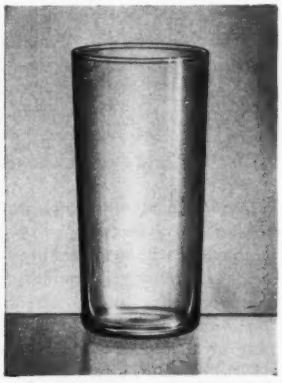
7. To produce, through their educational experience, a type of nurse more useful in our modern society.

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(Concluded from page 37)

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With loving hearts and willing hands
You welcome them, and pray
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To bring recovery, full and swift,
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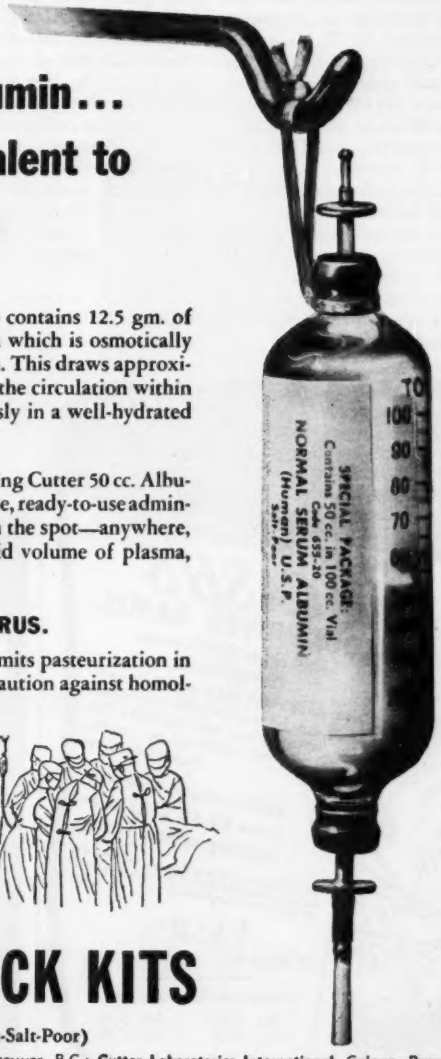
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B.C. Hospital Association

(Continued from page 46)

The program for one day of the pre-convention lectures was turned over to the B.C. Hospital Insurance Service, under the direction of Donald M. Cox, Assistant Commissioner. In this section of the program, Mrs. Edith Pringle, Reg.N., discussed procedures for transfer of long-term patients from acute general hospitals to other types of care. J. Mainguy spoke on staff organization and medical records; while fire hazards and methods of protection were described by T. Musto.

Labour relations, collective bargaining, and suggestions for bargaining on a regional basis rather than by individual hospitals, were subjects capably handled in a paper by K. Martin.

W. J. Lyle spoke on hospital finance and described the operation of the firm budget plan. Problems encountered in the collection of insurance premiums and in establishing eligibility for hospitalization benefits were discussed by P. D. Thomas.

Following the various presentations by B.C.H.I.S. officials, D. M. Cox presided over a lively round table discussion period dealing with questions relating to the operation of the insurance service.

Division Meetings

Several of the divisions of the association held separate meetings in conjunction with the convention. These included trustees, women's auxiliaries (see page 71), and administrators sections. The trustees section devoted considerable effort to reviewing and making recommendations on proposed model hospital by-laws developed by B.C.H.I.S. J. B. Paine of North Vancouver was re-elected to a second term as chairman.

The administrators division re-elected Paul E. Russell of Chilliwack as chairman and Harry Devine of Murrayville as secretary. The division recommended to the association that the insurance service be requested to add an active administrator to the Advisory Council. The incoming executive of the division was directed to continue working toward the formation of an administrators society and to arrange for incorporation of such a body.

The annual association banquet was under the sponsorship of the Hospital Auxiliaries Association, with Rev. Father Bertrand as main speaker of the evening. On another evening the Hon. A. D. Turnbull entertained in honour of the association executive.

Resolutions

A series of resolutions were approved by delegates at the final business session. Directed to the provincial government were resolutions recommending:

(1) that acute general hospitals be relieved of the financial burden of caring for chronic patients and for tuberculosis patients awaiting transfer to tuberculosis control units;

(2) that hospitals be paid for services rendered to every patient who is liable for the payment of premiums under the provisions of the Hospital Insurance Act and regulations;

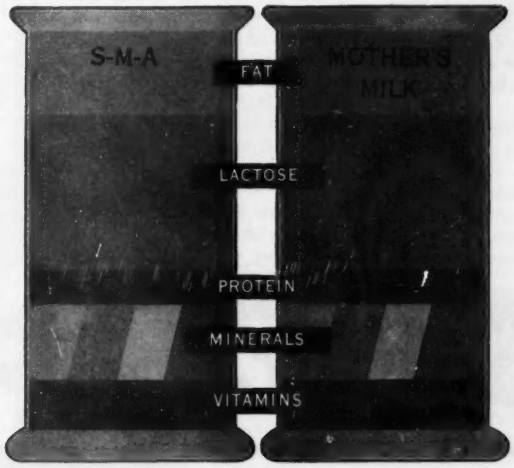
(3) that the section of the Hos-





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pital Insurance Act providing penalties for rendering accounts to beneficiaries be clarified;

(4) that the model hospital constitution and by-laws proposed by the insurance service be revised to provide greater elasticity;

(5) that the decision to make the three per cent provincial sales tax applicable to hospital purchases be reconsidered;

(6) that a small hospital administrator be included on the Hospital Advisory Council of B.C.H.I.S.

A resolution to be forwarded to the Department of National Health and Welfare concerns out-patient x-ray services paid through the Indian Health Services Branch and states that payment for this service can only be accepted at established hospital rates.

In recognition of many years of service to the Association and the hospitals of British Columbia, a resolution was unanimously approved conferring honorary membership in the Association on Dr. A. K. Haywood, Vancouver, E. S. Withers, New Westminster, and E. W. Neil, Duncan.

Provision was made for holding a special general meeting immediately following the Western Canada Institute for Hospital Administrators and Trustees which will be held in Vancouver in June, 1952.

Officers

Delegates re-elected Alfred H. J. Swencisky of Vancouver to his third successive term as president of the Association. Harvey Taylor of Port Alberni and A. Abrahamson of Revelstoke were elected first and second vice-president, respectively. K. K. Reid, New Westminster, remains a member of the executive as immediate past president. The other 16 members of the board of directors are the appointed representatives of the various regional councils and divisions of the association.

—*M.W.R.*

Cobalt Bomb Installed

Probably the world's most powerful cancer weapon, the cobalt bomb, has been installed in a special room in the War Memorial Children's Hospital, London, Ont. The department, to be known as the Ontario Institute of Radiotherapy, will be staffed by members of the Victoria Hospital Cancer Clinic, under the direction of Dr. Ivan Smith. The machine or bomb focuses deadly gamma rays on malignant cancer tissues in what is called cobalt 60 beam therapy. Ordinary cobalt that has been made radioactive is used in the bomb.

The special room, which will house the bomb, has been protected with a quarter-inch-thick lead sheeting over the ceiling and a heavy concrete wall around the room, which ranges in thickness from eight inches to one foot. In addition, eight feet of earth have been piled outside the building in the form of sand and sandbags.

The bomb weighs approximately 7,600 pounds and was financed by the Ontario Cancer Foundation, at an estimated cost of $50,000.

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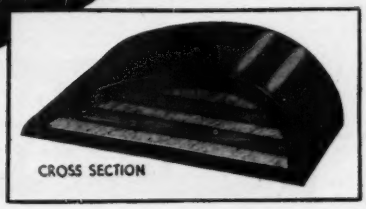
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Budget Time

(Continued from page 86)

the budget period.

The cost of laundry, as was the case in the cost of food, should be based on the expected departmental load in comparison with the load in the past. Laundry services are usually available to both patients and staff, rather than to patients alone, and for this reason the estimate of laundry costs on a patient-day basis may not be altogether valid. Without weighing all the laundry that goes through the department, a fair idea of the laundry load can be obtained by weighing the laundry through a period of one week every three to six months. The cost of housekeeping and cleaning supplies is not likely to vary to any extent with the number of patient days, but rather with the number of employees on the housekeeping staff. The fuel, electricity, and water will normally remain fairly consistent as will insurance premiums, office supplies, audit fees, telephone, and so on.

Balancing the Budget

When the first draft of the hospital budget has been prepared, the operating income for the budget period is totalled and the estimated operating expenditure is added up. If the total estimated income is less than the total estimated expenditure, then it will be necessary for you to consider either increasing your schedule of charges or decreasing your departmental expenditures in order to balance your budget. Or, you may be prepared to budget for a deficit.

If the estimated income is in excess of the estimated expenditure, you have the option of reducing your hospital rates or increasing your standards of service and still balancing your budget. For example, you may decide to reduce your charges for standard ward care, or you may decide to serve a little more or a little better food, to supply more drugs without charge, or to add to your nursing staff.

If the expenditures for the budget period appear to be high in comparison with the current expenditures or the experience of similar hospitals, you can explore every department in the hospital with a view to finding ways to save. In the matter of income, are charges being made for all the services supplied by the hospital, and is the collection policy such as to insure a minimum of bad debts? On the question of hospital supplies, have you looked into the possibility of calling for tenders on large purchases, of guarding your supplies adequately against theft, of reclaiming gauze, of servicing syringes, of instituting a menu system for meals, of using timers in the kitchen to cut down on culinary disasters, of using heated food carts to keep hot food hot and acceptable, and of putting the name of the hospital on every piece of equipment in use, particularly the linens? Have you explored the possibilities of standardization of equipment, drugs, medical supplies, and linens as a means of saving hospital dollars? Have you studied the physical

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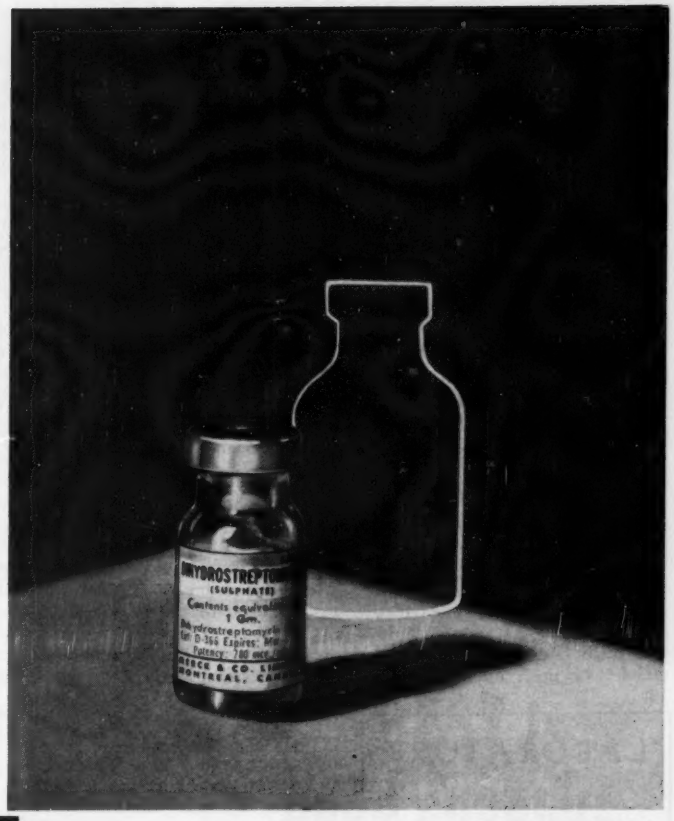


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location of equipment and personnel in each department, in relation to the flow of forms, patients or commodities, with a view to determining whether or not a rearrangement of facilities and personnel would speed up the flow of the work through the department. On the question of personnel, are your personnel policies such that you have a well trained and efficient staff, or have you a continual staff turnover? Have you studied whether or not the present personnel policies are the most inexpensive for your particular hospital?

As salaries and wages normally comprise more than 50% of the total hospital operating cost, have you investigated labour-saving devices to the fullest extent? Some people picture labour saving devices as fabulous machines where you put a stack of cards in at one end and watch salary cheques fly out the other end, or such equipment as electrically operated beds that rise up when you push one button and lower when you push another. Many common, everyday things can help you to cut down on your hospital labour costs. Telephones in the right places save steps, so do signal systems, elevators, stairs, laundry chutes, dumbwaiters and light switches. In the work savers you have electric floor scrubbers and polishers, multiple forms, duplicators, bookkeeping machines, writing boards, file sorters, dish washers, potato peelers, electric slicers, electric meat saws, electric mixers, taps on the soup kettles, flexible hoses on the kitchen and laundry water supplies, automatic boiler controls, and table tops that are easy to clean. Convenient filing systems, storage space and shelf space are great time-savers, as are motor driven garden tools and power tools in the woodworking shop.

After you have considered the draft budget and amended it where necessary, it is ready for presentation to the hospital governing board. The budget must be sufficiently flexible to meet ordinary hospital conditions and, at the same time, it must appear reasonable to the board of governors. After the governing board have approved the budget it is up to you, as administrator, to make it stick. Normal administrative aids that are employed to make a budget stick are discussed in the third of this series of articles which is entitled "Sticking to Your Budget". This article will be printed in the December issue of the Journal. Will you have your 1952 budget approved by that time?

How Rickets Got its Name

A note by that garrulous antiquary John Aubrey, which was first brought to light by Oliver Lawson Dick in his edition of the *Brief Lives*, 1949: "I will whilst 'tis on my mind insert this Remarque, viz—about 1620 one Ricketts of Newberye, a Practitioner of Physick, was excellent at the Curing Children with swoln heads, and small legges: and the Disease being new, and without a name, He being so famous for the cure of it, they called the Disease the Ricketts; as the King's Evill from the King's cureing of it with his Touch; and now 'tis good sport to see how they vex their Lexicons, and fetch it from the Greek Rhachis, the back bone."—*"The British Medical Journal"*

Anticipatory

Every morning the car used to stop outside the fence of the state asylum. Inside one of the inmates would be going through elaborate wind-up and pitching motions, using an imaginary ball. After studying him for a while the driver of the car, a well dressed businessman, would leave. After a few days of this the gatekeeper asked him, "Pardon me, sir, but why do you come here each day and study that poor fellow?"

"Well," came the answer, "if things continue the way they are in my business, I'll be in there some day catching for that fellow and I want to get on to his curves."—*"The Journal of Southern Medicine and Surgery"*

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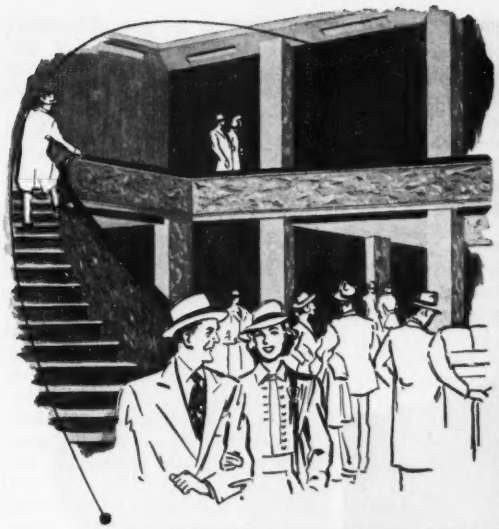
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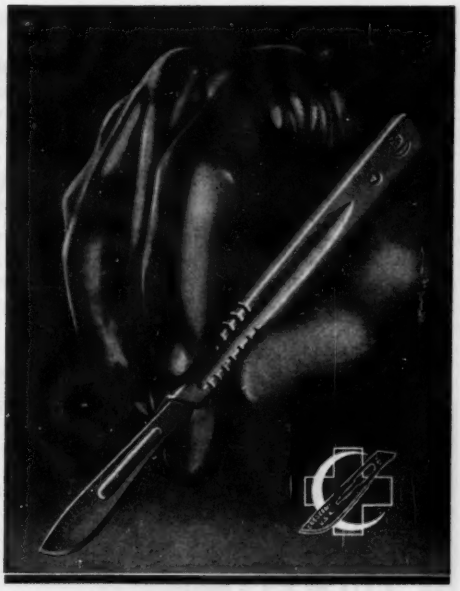
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Elementary Law

(Continued from page 78)

that an operation was necessary to effect a cure and that the operation should be made by making an incision in the foot or toe so as to drain off this joint any foreign matter that might be found therein. She consented to the operation upon the express condition that no bones should be removed. An anæsthetic was administered and in performing the operation the sesamoid bone was removed. An action of assault and battery was commenced based upon the contention that removal of the bone was unauthorized. The verdict was rendered in her favour. It was stated that the condition did not constitute an emergency. *(Rolater vs Train, 39 Oklahoma 572)*

Conversion of Property

Under certain circumstances, either through careless handling by hospital authorities or by actual theft on the part of hospital employees, the property of patients may disappear. This applies particularly to jewellery and money, as well as to clothing.

In respect of patient's personal property, hospitals may likewise take a release or acknowledgment of no responsibility on the part of the hospital. This may be impossible with: an unconscious patient; a mental patient; a patient unable physically to execute a document.

By the removal of articles from the patient's care, the hospital becomes the bailee. Under these circumstances the law doesn't require exceptional care, but it does require the care a reasonably prudent man would take of a like article of his own. Jewellery and money are therefore to be placed in a safe and clothes in a locker or compartment capable of being locked.

Case in illustration: A local authority operating a hospital admitted a patient, taking possession of certain jewellery and a cigarette case which she had in her handbag. The hospital was unaware that the articles were of value but, shortly afterwards, it received a letter from the patient's sister asking for confirmation of the contents of the patient's handbag and referring to diamonds. The hospital did not reply. The articles were entered in a book and stored with hundreds of others in envelopes on the floor in a room which a burglar would have had no difficulty in breaking into. They were not put in a safe even after receipt of the letter and they disappeared, presumably being stolen. Held by a judge of the K.B. Division, England, that the hospital was not entitled to assume that the patient's property was of no value and that the hospital was negligent in not storing the property in a safe, particularly after the letter of warning.

Defamation

This particular tort consists in the publication of a false and defamatory statement respecting any person without lawful justification. The defamatory state-

(Concluded on page 104)

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The author, JeHARNED, R.N., R.R.L., served as president of the American Association of Medical Record Librarians 1929-31, served on committees of A.H.A., and is associate professor of training program in Medical Record Library Science at Duke University School of Medicine and Hospital, Durham, North Carolina.

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Elementary Law

(Concluded from page 102)

ment may be made in words, written or spoken, or in acts or pictures.

In *libel* defamation is permanent and visible. In *slander* it is in spoken words or temporary form.

Why should libel and slander be referred to in connection with hospitals?

The member of a nursing staff has special opportunities of knowing with precision the degree of skill—or maybe the occasional lack of it—possessed by members of the medical profession. They should be drastically warned that to impute to a professional man lack of skill in his profession is actionable, without proof of damage. Similarly, superintendents and other senior officials in hospitals are called upon on occasions to make references to the proficiency of a medical person. A Board is called upon to decide whether a certain medical person is or is not to be admitted to the medical staff.

The following case is of interest. New Zealand Supreme Court: the plaintiff, a former Deputy Superintendent of South Otago Hospital, sued the defendant, then the Medical Superintendent, for slander. A deputation had waited upon the hospital board. The Chairman invited the defendant to address the deputation, which he did. In doing so, the defendant cited what he deemed to be unwise conduct by the plaintiff in the handling of certain patients with infectious diseases. The plaintiff sued the defendant for slander. Held that in substance the statements made by the defendant were true; held that the statements were made for the purpose of justifying the action of the Board; that there was nothing in these statements to justify the jury in saying that the defendant did not use the occasion for its proper purpose. Plaintiff's action dismissed. *(1928 New Zealand Law Reports)*

The hospital's appropriate precaution against every form of liability claim—negligence, assault, conversion, libel, slander or any other form of tort—is (1) public liability insurance; (2) adequate care.

(To be concluded in December)

Circular to Physicians

Within the very near future a synthetic narcotic known as methorphinan (dl-N-methyl-3-hydroxymorphinan) will be released to the medical profession in Canada.

It will, of course, appear on the market under a trade name but in any event it should be pointed out that methorphinan is included in the Schedule to the Opium and Narcotic Drug Act and comes under precisely the same narcotic regulations as morphine, heroin, cocaine, et cetera. Moreover, from information now available, it would appear that this drug possesses addiction properties of a nature necessitating great care being taken by doctors when prescribing it.—*K. C. Hossick, Chief, Division of Narcotic Control, Department of National Health and Welfare, Ottawa.*

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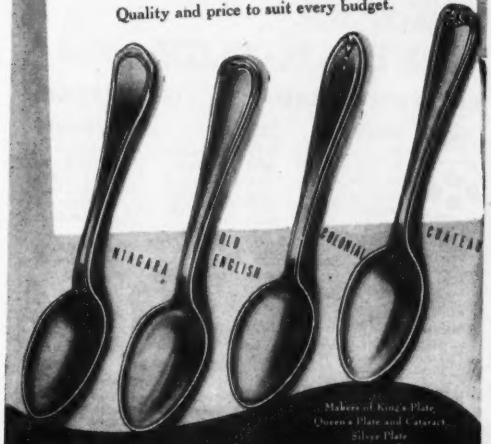
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Manitoba Convention

(Concluded from page 50)

independent "Hospital Rate Board", representing the hospitals, municipalities, and agencies of government, be set up for the establishment of indigent hospital rates and, further, that it be provided with the necessary accounting and technical assistance to enable it to discharge properly this function.

One of Canada's best known and loved trustees, Judge J. Milton George, was literally "drafted" and again accepted the presidency of the Association in the election of officers. Regional members of the Board of Directors are to be: J. Gardner, Dauphin; Frank Foster, Brandon; J. J. Reidiger, Morden; R. J. Hood, Carberry; Dr. H. Coppinger, Winnipeg; and Sister Berthe Dorais, St. Boniface. John McIntrye of Winnipeg was re-elected first vice-president, R. J. Hood, Carberry, became second vice- president, and Frank H. Silversides, Winnipeg, was named treasurer. —*M.W.R.*

Coming Conventions

Nov. 20-24—Third Maritime Institute for Hospital Administrators, Trustees, and Department Heads, Halifax, N.S.

Nov. 26-30—A.H.A. Institute on Hospital Laundry Management, Kenmore Hotel, Boston, Mass.

Jan. 21-Feb. 1—Cerebral Palsy Institute, sponsored by the Co-ordinating Council for Cerebral Palsy in New York City Inc., New York City, N.Y.

Feb. 18-19—Sectional Meeting of the American College of Surgeons, Quebec City, P.Q.

Mar. 31-Apr. 1—Sectional Meeting of the American College of Surgeons, Vancouver, B.C.

May 16-17—Sectional Meeting of the American College of Surgeons, Toronto, Ont.

May 18-21—Annual Convention of the Canadian Society of Laboratory Technologists, General Brock Hotel, Niagara Falls, Ont.

June 1-6—Biennial Meeting of the Canadian Nurses' Association, Chateau Frontenac, Quebec City, P.Q.

June 10-12—Canadian Dietetic Association Convention, University of British Columbia, Vancouver, B.C.

June 15-18—Canadian Public Health Association, Fort Garry Hotel, Winnipeg, Man.

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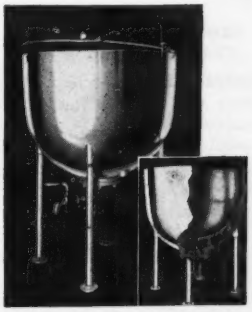
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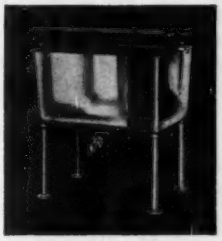
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Saskatchewan Convention

(Concluded from page 44)

National Health Program and, in particular, pointed out its effects in Saskatchewan.

The aims and activities of the American Hospital Association were described by Leonard P. Goudy, a former Saskatchewan administrator and now secretary of the Council on Administrative Practice of the A.H.A. Dr. H. E. Baird, Saskatchewan Hospital Association's representative on the provincial civil defence committee, outlined the work accomplished by that committee.

Lola Wilson, registrar of the Saskatchewan Registered Nurses' Association, urged administrators and trustees to insist upon registration of nurses as the surest method of maintaining high quality and reliable nursing service.

Resolutions

Resolutions passed by the Association at its final sessions urged the following:

1. Exemption of hospital bank accounts from attachment;
2. Removal of the 30-day waiting penalty when hospital tax is paid prior to January 1st;
3. Payment to hospitals by the insurance plan for all persons liable for payment of hospital tax;
4. Determination of Association policy by the membership at large, rather than the executive.

Officers

Satisfaction with the efforts of the officers and executive during the past year was emphasized by the re-election of most for a further term.

President: H. H. Bassett, Prince Albert.
Vice-President: H. B. Myers, Rosetown.
Secretary - treasurer: John Smith, Yorkton.
Executive: Dr. H. E. Baird, Regina; S. N. Wynn, Yorkton; J. C. Saunders, Saskatoon; Norman Hall, Shaunavan; and M. F. Kushnir, Canora.

—*M.W.R.*

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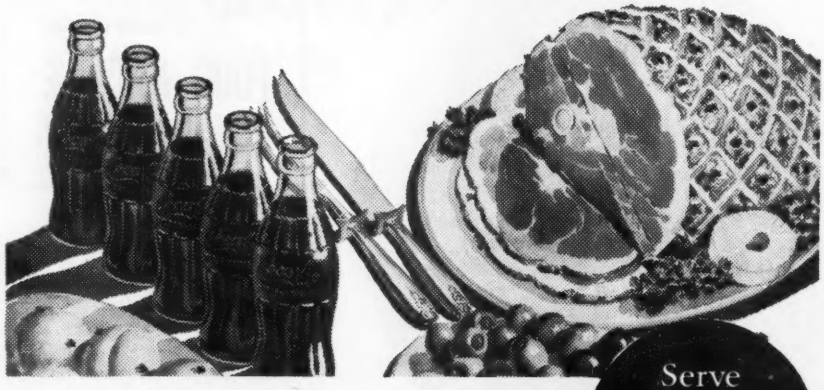
Appointment of Interns

(Concluded from page 72)

7. Result: By this scheme, each hospital will secure the interns considered by it most desirable and each medical student will receive the best appointment open to him in accordance with his expressed preference.

8. Note Re Approved Hospitals: Medical students should note that, for those individuals who desire certification or fellowships in the Royal College of Physicians and Surgeons of Canada or who desire to practise in the U.S.A. and write the examinations of the National Board of Medical Examiners, these two bodies require candidates to have interned in hospitals approved either by the Canadian Medical Association or American Medical Association.

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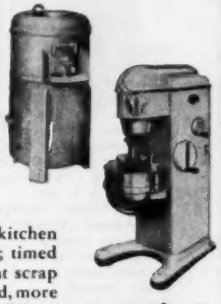
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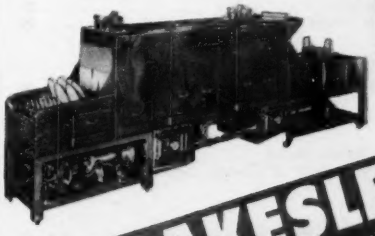
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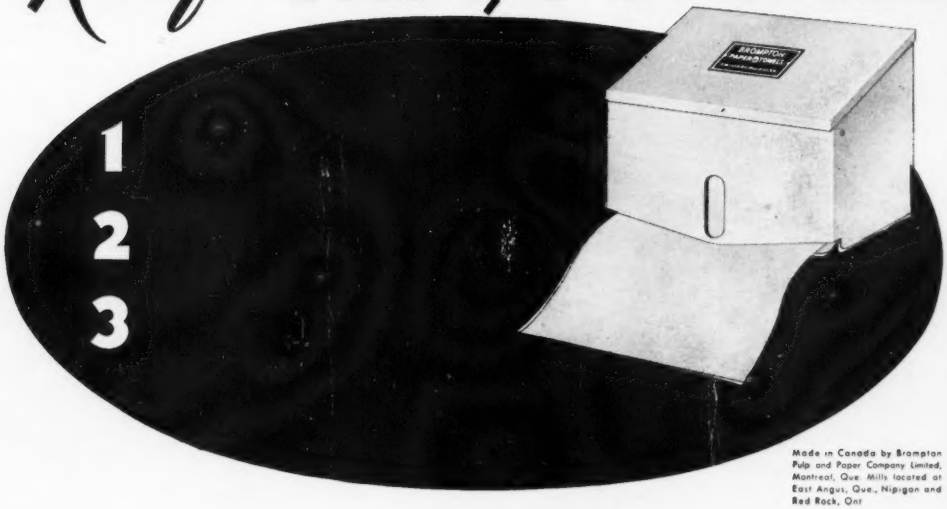
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